

Palliative care and COVID-19

- This webinar will start at 8.30pm IST / 4pm UK.
- You can watch the recording on the [AHSN Network](#) and SAHF YouTube channels afterwards.
- Please use the chat to submit your questions.

Panellists



- **Professor Anoop Chauhan**, Professor of Respiratory Medicine, Portsmouth Hospitals NHS Trust



- **Dr Iain Lawrie**, Macmillan Consultant & Honorary Clinical Senior Lecturer in Palliative Medicine, Manchester University Hospitals NHS Foundation Trust



- **Professor Anupam Prakash**, Professor of Medicine, Lady Harding Medical College, Delhi



- **Dr R Rajasekar**, Senior Consultant Physician – Chairman R R Charitable Trust, Tamil Nadu



- **Dr Sabrina Bajwah**, Clinical Senior Lecturer King's College London, Honorary Consultant Palliative Care, Palliative Care Lead NIHR South London CRN



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University Hospitals
of Leicester
NHS Trust

Welcome

The webinar is about to begin.

Professor Anoop Chauhan

Professor of Respiratory Medicine,
Portsmouth Hospitals NHS Trust

Overview of webinar

- Identifying needs in COVID end-of-life care and recognising the dying
- The pharmacologic toolbox in palliative care
- Management of breathlessness
- Agitation and delirium
- Hydration, infusions and loss of oral route
- Spiritual and psychosocial support
- Question and answer session

COVID palliative care

Dr R Rajasekar

Senior Consultant Physician – Chairman R R Charitable Trust,
Tamil Nadu

Dr. R. RAJASEKAR.,

MD.,FICP.,FACP (USA), FRCP (Glasgow, Ireland, London & Edinburgh)
Physician and Diabetologist.
KUMBAKONAM, TAMIL NADU



- **Faculty Council Member – ICP**
- **Faculty for Cardio Diabetic courses-PHFI,**
- **President-Clinical Cardio Diabetic Society of India**
- **Past Governing Council Member – API.**
- **Past Treasurer -ACP-India Chapter**
- **Author of My Mnemonics in Medicine-1st, 2nd, 3rd & 4th Edition**
- **Editor of ICP Monographs - Anemia, Clinical Medicine, Fluid, Electrolyte & Acid- Base Disturbances, Appraisal of Clinical Significance of biomarkers & Section Editor of Year Book Medicine 2018,2019,2020.**
- **Section Editor year book of Medicine2018 & 2019 and many other Multiple Books**
- **Editor in Chief –International Journal of Cardiometabolism.**
- **Written more than 100 articles-API Medicine Update, Progress in Medicine, JAPI, JIMA, Medical Journals – etc**
- **Delivered many talks, orations in state and National Conferences-IMA,API,RSSDI. Etc**
- **Received Master Teacher Award by API. 2020.**
- **Revered Teacher award by East Zone API-Assam 2017& Best Physicians award-2018 by Gulbarga college , Karnataka**
- **Best Doctor Award by Tamil Nadu Govt. and Doctors Day Award from State IMA**

DEFINITION

Palliative care in covid-19 is a multifaceted integrated approach to improve the quality of life of the patients and their families facing the problem associated with life threatening covid 19.

- **Palliative treatment focusses on prevention and relief of suffering by means of early identification, assessment and treatment of physical, psychosocial and spiritual stressors.**
- **Palliative care includes but not limited to end of lifecare. Patient care should be integrated with curative treatment.**

- **Basic palliative care includes relief of dyspnea and other symptoms.**
- **Palliative care intervention should be made accessible at each institution that promotes care for persons with covid 19**
- **In hospitals palliative care does not require a separate ward or department.**
- **Palliative care can be provided in any setting.**

- **To consider opioids and the pharmacologic and non pharmacologic intervention for relief of dyspnea that is refractory to the treatment of underlying cause and /or as apart of end of life care.**
- **The narrow therapeutic margin of opioids in the management of dyspnea requires that opioids are prescribed in accordance with evidence based treatment protocols and that the patients are closely monitored to prevent negative un indented effects due to inappropriate use of opioids.**

Palliative therapy also includes

- Managing pain and symptoms**
- Ensuring comfort in dying**
- Supporting patients and families to understand and decide treatment**
- Interaction with patients, families colleagues and community.**
- Spiritual care, team support, and guidance of self care.**

COVID palliative care

Professor Anupam Prakash

Prof. Medicine, & Head of Acci. & Em., LHMC, Delhi
President, Delhi Diabetic Forum, Indian Society for Atherosclerosis Research
Editor-in-Chief, Indian Journal of Medical Specialities
Member, Governing Body of API

COVID Palliative Care – Delirium & Agitation

- Quiet room, Window side bed
- Avoid physical restraints
- Oral Haloperidol 0.5 mg BD (10-15 mg/d)

- Inj. Haloperidol 2.5 mg iv 6-8 hrly
- Inj Midaz 2mg iv 4h (10-15 mg/24h iv infusion)
(Phenobarbitone/Propofol in ICU setting)

COVID Palliative Care – Pain

- Mild pain - Oral PCM or if not taking orally, im
- Neuropathic pain - Gabapentin 100-300 mg HS and uptitrate to 3g/day
- Moderate pain - Morphine 2-3 mg 4 hrly or Fentanyl 0.2-0.5 mcg/kg/h

- Inj. Metoclopramide 10-20 mg for vomiting
- Inj. Glycopyrolate 0.2 mg iv 6h for respi secretions

COVID Palliative Care – Psychosocial support

- Communication
 - Doctor-Patient
 - Difficult
 - Fear, panic, far from relations, future uncertain
 - Barriers
 - Long time to recovery
 - Dignity and compassion
 - Doctor-Family
 - When, where, How, state of denial

COVID Palliative Care

- Psychosocial support
 - Ensure comfort
 - Check emotions
 - Reassure family and patients
 - Assess need for information & elicit concerns
 - Deliver information with empathy
 - Acknowledge and validate emotions
 - Address anger & explore reason

COVID Palliative Care

- Loss, grief and bereavement care
- Recognise distress
- Recognise grief
- Rule out psychiatric morbidity
- Intervention for grief management
- Seek mental health expertise if complicated/difficult grief

COVID Palliative Care

- Psychoeducation
 - Honest information in simple & accurate terms
 - Avoid false reassurances
 - Maintain calm behaviour
- Reassurance
- Catharsis
- Help normalize anger and grief
- Promote realistic hope & goal setting
- Relaxation techniques, yoga, meditation
- Pharmacotherapy for psychiatric morbidity

Management of breathlessness in COVID

Dr Sabrina Bajwah

Clinical Senior Lecturer King's College London,
Honorary Consultant Palliative Care, Palliative Care Lead NIHR
South London CRN



Management of breathlessness in COVID

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@SBajwah

The screenshot displays the European Respiratory Journal (ERJ) website. At the top, the journal's logo and name are visible, along with a search bar and a navigation menu. The main article title is prominently displayed, followed by the authors' names and the journal's publication details. Below the title, there are tabs for 'Article', 'Figures & Data', and 'Info & Metrics', along with a PDF icon. The 'Extract' section provides a summary of the article's content, discussing the global impact of COVID-19 and the need for supportive care. The 'Acknowledgments' section thanks the patients and members of the public at the European Lung Foundation and Cicely Saunders Institute, as well as Howard Almond and Sarah Dix. On the right side, there is a red button to 'View this article with LENS', a 'Table of Contents' section, and a list of utility links including Email, Print, Alerts, Citation Tools, Request Permissions, Share, and Full Text (PDF).

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Managing the supportive care needs of those affected by COVID-19

S. Bajwah, A. Wilcock, R. Towers, M. Costantini, C. Bausewein, S. T. Simon, E. Bendstrup, W. Prentice, M. J. Johnson, D. C. Currow, M. Kreuter, A. U. Wells, S. S. Birring, P. Edmonds, I. J. Higginson
European Respiratory Journal 2020; DOI: 10.1183/13993003.00815-2020

Article Figures & Data Info & Metrics

Extract

Globally, the number of people affected by coronavirus disease 2019 (COVID-19) is rapidly increasing. In most (>80%), the illness is relatively mild and can be self-managed out of hospital. However, in about 20% the illness causes respiratory compromise severe enough to require hospital admission [1]. Patients with severe and critical disease need full active treatment. This may include oxygen for hypoxaemia and ventilatory support, along with optimal management of complications, e.g. super-imposed bacterial infection, and any underlying co-morbidities, e.g. chronic obstructive pulmonary disease, congestive heart failure. To date, no antiviral agent has shown to be effective in treating the disease [2].

Acknowledgments

Thank you to all the patients and members of the public at the European Lung Foundation and Cicely Saunders Institute as well as Howard Almond (Action for Pulmonary Fibrosis) and Sarah Dix for their valuable contributions to drafting of the information leaflets.

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EUROPEAN RESPIRATORY journal
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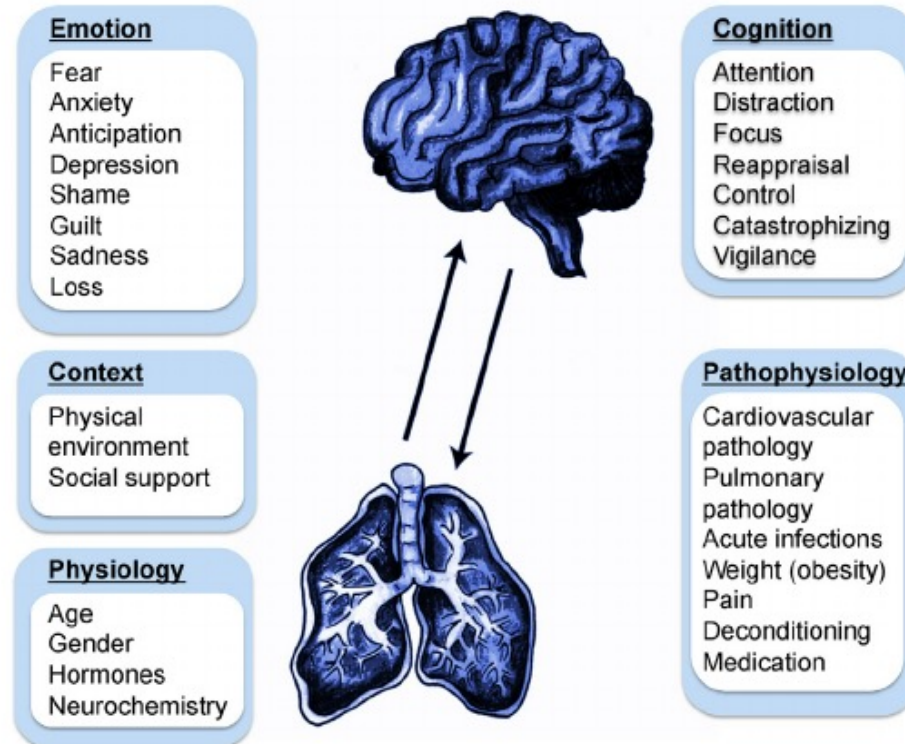
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Causes of breathlessness in COVID

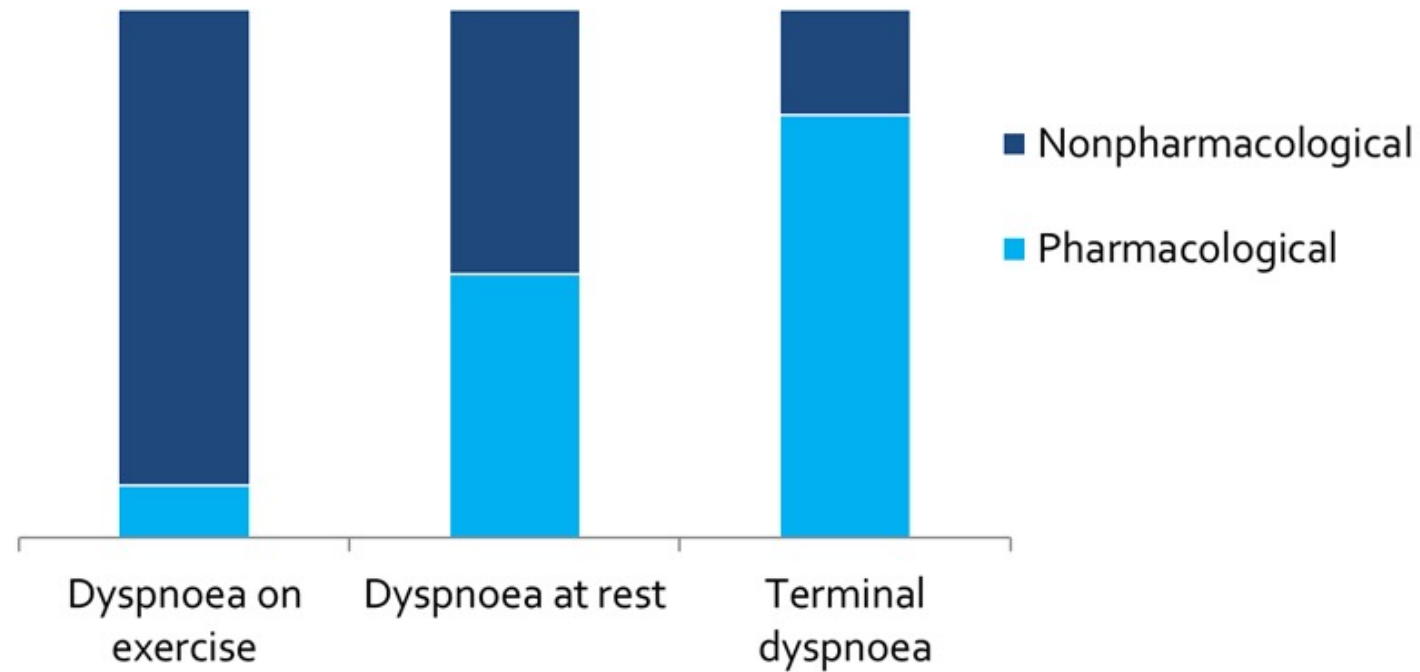
- Viral lung infection
- Interstitial pneumonia with reduction in lung diffusing capacity
- Acute Respiratory Distress Syndrome
- Pulmonary Embolism
- Emotional, environmental, cultural and social factors

The complicated nature of breathlessness



- Non-pharmacological measures
 - Meet information needs and allay anxieties
 - Relaxation therapies
 - Breathing control/repositioning
- Pharmacological measures
 - Oxygen
 - Opioids
 - Benzodiazepines

Balance of Management Approaches



Non-pharmacological management

Cicely Saunders International | **NIHR** | National Institute for Health Research | **South East London Commissioning Alliance** | **NHS** Partnership of Clinical Commissioning Groups




Managing breathlessness at home during the COVID-19 outbreak

Many pre-existing conditions, such as heart or lung diseases, cause breathlessness. Breathlessness can be very frightening and distressing, even in milder cases, and may be worsened by fears relating to the corona virus. During the current corona virus outbreak, you may have reduced access to your usual support networks. It is important that you continue the usual treatments for your underlying conditions (e.g. inhaler). It's okay to contact your usual health and social care team for support.

If you think you may have corona virus, please use the 111 online corona virus service to find out what to do (111.nhs.uk). If you are unable to use the online service, please phone 111.

The following steps may help you feel less breathless. You might find some of these steps more helpful than others. Try them out and use the ones that you find most helpful:

Finding a comfortable position can ease your breathlessness, try these:

<p>Sit upright in a comfortable armchair with both arms supported on the chair arms or cushions. Let your shoulders drop and relax. Rest the soles of your feet on the floor.</p> 	<p>Sit on a chair and let your body flop forwards. Rest both arms on a table or your knees to support you.</p> 	<p>Lie on your side propped up with pillows under your upper body. Tuck the top pillow into your neck to support your head. Rest your top arm on a pillow placed in front of your chest and your top leg on another.</p> 
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In your comfortable position, loosen your wrists, fingers and your jaw.

Abdominal and tummy breathing

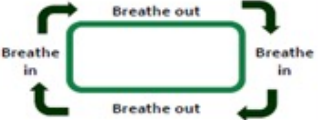
Rest a hand on your tummy and breathe in gently to feel your tummy rise. Then breathe out slowly through your nose or your mouth. Rest and wait for the next breath to come. You may find it helpful to purse your lips while you breathe out slowly as though you were making a candle flame flicker.

Slowing down

When you are comfortable with the tummy breathing, try to slow down the speed of your breathing. When you slow down, your breathing becomes deeper, which is more efficient. Imagine air filling your tummy like a balloon. Practicing regularly will make it easier to do when you are breathless.

Breathe a rectangle

- Once you have found a comfortable position, look around for a rectangle. This might be a window, a door, picture, or even a book or television screen.
- Now follow the sides of the rectangle with your eyes as you breathe, breathing in on the short sides and out on the long sides.
- Gradually slow the speed that your eyes move round the rectangle, pausing at the corners to help slow your breathing.



Cooling the face

Cooling the face, especially around the nose, can help reduce how breathless you feel. Try wiping a cool wet flannel on your nose and upper cheeks of your face. The use of fans is not being recommended during the coronavirus outbreak due to the risk of it spreading infection.

Tips for living with breathlessness at home:

- When walking**
 - Move at a comfortable pace, and breathe steadily
 - Avoid holding your breath, or trying to move or turn too fast
 - Pace your breathing to your steps; breathe in over one step, breathe out over the next two steps
 - Use walking aids if they help you
 - Stop and rest whenever you need to.
- When climbing steps or stairs**
 - Use the handrail when climbing stairs and take the steps slowly. Try resting for at least five seconds every few steps.
- When feeling anxious**
 - Remember that this is a worrying time with a lot of uncertainty, so it is natural to feel worried
 - There are many ways to deal with worried feelings. These include mindfulness, listening to relaxing music, or doing gentle activity such as gardening, yoga or singing.
- When eating and drinking**
 - Take small meals often, rather than one large one
 - Eat smaller mouthfuls
 - Avoid foods that are difficult to chew, add sauces when possible
 - Drink sips of fluid often to avoid becoming dehydrated.
- During day to day activities**
 - Keep things you use often close to hand
 - Have a charged phone close to your bed or armchair
 - Plan ahead with your chores or daily activities, such as bathing or housework
 - Spread your activity throughout the day
 - Have everything you need before you start an activity
 - Rest between activities or when your breathing begins to feel uncomfortable.
- Keep in touch**
 - Stay in touch with friends and relatives by using the phone and other technology and writing letters.
- Keep active**
 - It is important to stay as active as you can, to prevent your muscles becoming weaker.

It's okay to ask for help.

Please continue to contact your usual health and social care teams if you need further support.

Further resources for people with breathlessness:

- Cicely Saunders Institute: kcl.ac.uk/cicelysaunders/research/symptom/breathlessness
- St Christopher's Hospice: stchristophers.org.uk/videos/managing-breathlessness
- Hull York Medical School: breathlessness.hyms.ac.uk
- British Lung Foundation: blf.org.uk/support-for-you/breathlessness/how-to-manage-breathlessness
- Life of Breath Project: lifeofbreath.org/category/resources

References: Bausewein et al. 2008. *Cochrane CD005623*; Brighton et al. *Thorax* 2019;74:270-1. Positioning images reproduced with permission of the Cambridge Breathlessness Intervention Service.

How to cite this resource: Higginson LJ, Maddocks M, Bayly J, Brighton LJ, Hutchinson A, Booth S, Ogdan M, Farquhar M. on behalf of the NIHR Applied Research Collaborative Palliative and End of Life Care Theme. April 3rd 2020. Managing your breathlessness at home during the corona virus (COVID-19) outbreak.

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<https://www.kcl.ac.uk/cicelysaunders/resources/khp-gp-breathlessness-resource.pdf>

Symptom management in severe COVID-19

Symptom/need	Clinical indication	Recommendation
Distressing breathlessness at rest		<ul style="list-style-type: none">• Stat dose morphine 2.5 mg SC/IV + midazolam 2.5 mg SC/IV (reduce both to 1.25 mg if eGFR <30 or elderly) <p><i>If continuous infusion is available</i></p> <ul style="list-style-type: none">• Morphine 10 mg + midazolam 10 mg CSCI/IV over 24 h OR morphine 5 mg + midazolam 5 mg CSCI/IV over 24 h (if eGFR <30 or in the elderly)• In addition, prescribe morphine 2.5 mg + midazolam 2.5 mg SC/IV p.r.n. 4 hourly (1.25 mg for both if eGFR <30 or in the elderly) <p><i>If continuous infusion is not available</i></p> <ul style="list-style-type: none">• Morphine 2.5 mg SC/IV + midazolam 2.5 mg SC/IV 4 hourly (1.25 mg for both if eGFR <30 or in the elderly)• In addition, prescribe morphine 2.5 mg SC/IV + midazolam 2.5 mg SC/IV p.r.n. 4 hourly (1.25 mg for both if eGFR<30 or in the elderly) <p>Monitor patients receiving opioids for undesirable effects, particularly nausea and vomiting, and constipation. Depending on individual circumstances, prescribe a regular or p.r.n anti-emetic and a regular laxative.</p>

<https://clincalc.com/Benzodiazepine/>

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Mr RB-64 year old non English speaking with metastatic lung cancer

- 04/01/21
 - Admitted with COVID pneumonia
 - Given information leaflet and focus on non-pharmacological management of breathlessness
 - PRN subcutaneous morphine 2.5mg and PRN subcutaneous midazolam 2.5mg
- 07/01/21
 - Poor response to treatment
 - Accessing PRN doses of morphine (2* 2.5mg) anxious ++
 - 24 hourly subcutaneous Syringe pump: morphine 10mg + midazolam 10mg
 - PRN subcutaneous morphine 2.5mg and PRN subcutaneous midazolam 2.5mg
- 08/01/21
 - agitation ++, oxygen saturations 75% on room air on 15L rebreather
 - Accessing PRN doses of morphine (2* 2.5mg)+ midazolam (3* 2.5mg)
 - 24 hourly subcutaneous Syringe pump: morphine 15mg+ midazolam 25mg
 - PRN subcutaneous morphine 2.5mg and PRN subcutaneous midazolam 5mg
 - Family visited
 - Died comfortably overnight

• Key messages:

- Proactive management of symptoms
- Palliation of suffering important part of care, irrespective of prognosis
- Urgent care (parallel) planning, as patients can deteriorate rapidly – alongside medical management plan
- Clear and timely communication – hoping for the best with acknowledgement that patient may be sick enough to die

PRACTICE

Check for updates

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Palliative care for patients with severe covid-19

Ruth Ting,¹ Polly Edmonds,¹ Irene J Higginson,^{1,2} Katherine E Sleeman^{1,2}

What you need to know

- Many patients with severe covid-19 experience distressing symptoms, including breathlessness and agitation. Palliation of suffering is an important part of care irrespective of prognosis.
- Patients with severe covid-19 may deteriorate rapidly. It is therefore useful to have a strategy in place for managing deterioration and potential death for those not suitable for escalation to intensive care, which runs alongside the acute medical management plan.
- Clear and timely communication with the patient (if they are able) and their carers is essential. Conveying hope that treatments will help needs to be sensitively balanced with explicit acknowledgement that patients are sick enough to die.

"To care sometimes, to relieve often, and to comfort always."

Originally attributed to William Osler, Edward Toulson, and Hippocrates

On 11 March 2020 covid-19 was declared a pandemic by the World Health Organisation. Approximately one in five people with covid-19 aged over 65 require hospitalisation.¹ An observational study of 20 133 people with covid-19 requiring hospitalisation in the UK found that 26% died, 46% were discharged alive, while 28% remained inpatients at the time of reporting.² The case fatality rate varies worldwide, with the risk of death higher among people who are older, male, multimorbid, of black, Asian, and minority ethnicity, and from areas of higher deprivation.^{3,4}

Palliative care is commonly misunderstood as only being relevant for people who are dying. However, the relief of suffering, through provision of holistic and compassionate care, is an essential component of care for all patients with life threatening illness. This article outlines the palliative approach to the management of patients with severe covid-19 in hospital and community settings, focusing on the management of distressing symptoms, planning ahead, communicating with patients and their families, and grief and bereavement. The clinical triage of critically ill patients with severe covid-19 (to determine those most likely to benefit from escalation to high dependency or intensive care) is outside of the scope of this article.

Symptoms in patients with severe covid-19

Symptoms can escalate rapidly among patients with severe covid-19. An early case series from Wuhan in China of hospital presentations found that the median time from first symptom to breathlessness was five days, and to acute respiratory distress syndrome (ARDS) was eight days.⁵ A report of 6100 patients who died with covid-19 in Italy found that the median time from onset of symptoms to hospitalisation was five days, and from onset of symptoms to death was nine days.⁶ Therefore, an anticipatory approach to symptom management for people with severe covid-19 is key.⁷

Among decedents and survivors with covid-19, breathlessness, cough, and fatigue are the most common symptoms.⁸ A case series of 400 patients with severe covid-19 who were referred to three hospital palliative care teams in London, UK, found breathlessness and agitation were the most common symptoms, alongside drowsiness and delirium.⁹

How can breathlessness in severe covid-19 be managed?

Opioids

The mainstay of pharmacological management of severe breathlessness is opioids, with morphine being the option of choice in the absence of renal impairment.¹⁰⁻¹² Opioids should be considered in patients who are severely breathless at rest or on minimal exertion. If the patient is able to take oral medication, immediate release oral morphine can be used (such as 2.5 mg every 4 hours). If the patient is unable to swallow or is drowsy or unconscious morphine can be given parenterally to relieve breathlessness. If the patient remains breathless despite the use of opioids, involvement of a palliative care team should be considered.

The use of continuous parenteral infusions can be useful to ensure a consistent background dose of opioid and enable titration according to symptom severity. An early case series of 100 hospitalised patients with covid-19 who were referred to palliative care found that opioids were usually effective for palliation of breathlessness, with a median dose of 60 mg (range 5-30 mg) subcutaneous morphine over 24 hours.¹³ A retrospective audit of 36 hospitalised patients with covid-19 who died outside critical care found that 26 of them had a subcutaneous infusion at the time of death, and the total mean opioid dose (subcutaneous morphine equivalent) during the final 24 hours was 64 mg.¹⁴

In people with severe covid-19, who may deteriorate rapidly, there should be a low threshold for the use of parenteral infusions so that patients do not die before their symptoms can be controlled. Continuous parenteral infusions have the advantage of reducing the requirement for frequent "as needed" doses. Some symptomatic patients with severe breathlessness will still require "as needed" doses, and these should remain available to the patient to support symptom management. Use of an alternative opioid, such as fentanyl or alfentanil, should be considered in people with significant renal impairment, taking care to achieve equianalgesic starting doses.

BMJ 2020;370:m2710. doi:10.1136/bmj.m2710. Copyright 2020. All rights reserved. No reuse allowed without permission.

COVID Publications to Date

1. **Bajwah S, Wilcock A, Towers R, Costantini M, Bausenwein C, Simon S, Bendstrup E, Prentice W, Johnson MJ, Currow DC, Kreuter M, Wells AU, Birring SS, Edmonds P, Higginson IJ.** Managing the supportive care needs of those affected by COVID-19. *Eur Respir J* Apr 2020; doi.org/10.1183/13993003.00815-2020.
2. **Lovell N, Maddocks M, Etkind SN, Taylor K, Carey I, Vora V, Marsh L, Higginson IJ, Prentice W, Edmonds P, Sleeman KE.** Characteristics, Symptom Management, and Outcomes of 101 Patients With COVID-19 Referred for Hospital Palliative Care. *J Pain Symptom Manage*. Apr 2020;S0885-3924(20)30211-6. doi:10.1016/j.jpainsymman.2020.04.015.
3. Costantini M, **Sleeman KE, Peruselli C, Higginson IJ.** Response and role of palliative care during the COVID-19 pandemic: A national telephone survey of hospices in Italy. *Palliat Med*. 2020 Apr 29;269216320920780. doi: 10.1177/0269216320920780.
4. Selman LE, Chao D, Sowden R, **Marshall S, Chamberlain C, Koffman J.** Bereavement support on the frontline of COVID-19: Recommendations for hospital clinicians. *J Pain Symptom Manage*. 2020 May 3;S0885-3924(20)30244-X. doi: 10.1016/j.jpainsymman.2020.04.024.
5. Shamieh O, Richardson K, Abdel-Razeq H, **Harding R, Sullivan R, Mansour A.** COVID-19-Impact on DNR Orders in the Largest Cancer Center in Jordan. *J Pain Symptom Manage*. May 2020;S0885-3924(20)30242-6. doi:10.1016/j.jpainsymman.2020.04.023.
6. **Koffman J, Etkind S, Gross J, Selman L** Clinical uncertainty and Covid-19: Embrace the questions and find solutions (Editorial) *Palliative Medicine* 2020, DOI: 10.1177/0269216320933750
7. **Koffman J, Etkind S, Gross J, Selman L.** Uncertainty and Covid-19: How are we to respond? *JRSM* 2020 DOI: 10.1177/0141076820930665
8. Shamieh O, Richardson K, Abdel-Razeq H, **Harding R, Sullivan R, Mansour A.** [COVID-19-Impact on DNR Orders in the Largest Cancer Center in Jordan.](#) *J Pain Symptom Manage*. 2020 Aug;60(2):e87-e89. doi: 10.1016/j.jpainsymman.2020.04.023. Epub 2020 May 5. PubMed PMID: 32387138; PubMed Central PMCID: PMC7199683.
9. Selman LE, Chao D, Sowden R, **Marshall S, Chamberlain C, Koffman J.** [Bereavement Support on the Frontline of COVID-19: Recommendations for Hospital Clinicians.](#) *J Pain Symptom Manage*. 2020 Aug;60(2):e81-e86. doi: 10.1016/j.jpainsymman.2020.04.024. Epub 2020 May 4. PubMed PMID: 32376262; PubMed Central PMCID: PMC7196538.
10. **Afolabi OA, Abboah-Offei M, Namisango E, Chukwusa E, Oluyase AO, Luyirika EBK, Harding R, Nkhoma K.** Do the clinical management guidelines for Covid-19 in African Countries reflect the African quality palliative care standards? A rapid review. [Preprint]. *Bull World Health Organ*. E-pub: 26 May 2020. doi: <http://dx.doi.org/10.2471/BLT.20.267120>
11. **Antunes B, Bowers B, Winterburn I, Kelly MP, Brodrick R, Pollock K, Majumder M, Spathis A, Lawrie I, George R, Ryan R, Barclay S.** Anticipatory prescribing in community end-of-life care in the UK and Ireland during the COVID-19 pandemic: online survey. *BMJ Support Palliat Care*. 2020 Jun 16;. doi: 10.1136/bmjspcare-2020-002394. [Epub ahead of print] PubMed PMID: 32546559.
12. **Ting R, Edmonds P, Higginson IJ, Sleeman K.** Palliative care for patients with severe covid-19. *BMJ* 2020;370:m2710 <http://dx.doi.org/10.1136/bmj.m2710>



Thank You

 @SBajwah

UK regional experience of first wave

Dr Iain Lawrie

Macmillan Consultant in Palliative Medicine

Immediate Past President, Association for Palliative Medicine

Regional audit

- North West England
- wave 1 of pandemic (January – July 2020)
- 927 patients
 - male 59% / female 41%
 - mean age 80 (median 82 / range 37-105)
 - SPC involved in last 5 days, but mostly in last day before death
 - most deaths in April 2020
 - individualised plan of care in 61%

Prescribing

- opioids
 - prescribed 83%; used in 64%, mostly in last day of life; syringe driver 24%
- midazolam
 - prescribed 82%; used in 58%, mostly in last day of life; syringe driver 21%
- haloperidol
 - prescribed 11%; used in 26%; syringe driver 3%
- levomepromazine
 - prescribed 54%; used in 10%; syringe driver 6%
- anti-secretory medication
 - prescribed 78%; used in 32%; syringe driver 8%

- ❖ injections should be SC
- ❖ little place for IV at EoL
- ❖ IM injections hurt!

Someone with the patient

- interesting (and upsetting) findings ...
 - only 41% of patients had someone with them when they died
 - in only 16% of cases was this a friend or relative
- where someone was with the patient
 - they were more likely to be prescribed 'anticipatory' medications
 - they were more likely to receive medications for pain or agitation

What does this tell us?

- patients only require low doses of medication at EoL with COVID
- ‘as required’ medication is used less than we may have expected
- syringe drivers were used in less than 25% of cases
- having someone sitting with the patient resulted in more use of medications ... needs more exploration
- involving palliative care services increases symptom control interventions

Thank you



Q&A session

Led by Dr Alison Tavaré, West of England Regional Clinical Lead for COVID Oximetry @home

Please ask any questions using the chat function.



SOUTH ASIAN HEALTH FOUNDATION



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The **AHSN** Network



Centre for BME Health
reducing health inequalities



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SAHF/AHSN UK-India COVID-19 webinar series TO UPDATE



MANAGEMENT OF LONG COVID

Thursday 20 May 8.30-9.30pm (India Standard Time) / 4-5pm (UK BST)

This is the sixth in a series of UK-India COVID-19 webinars from the South Asian Health Foundation, Academic Health Science Network (AHSN Network) and Learn with Nurses, sharing NHS experiences of COVID-19 specifically regarding the identification, implications and management of long COVID, with health and care professionals in other countries.

- What is long COVID
- Setting up a long COVID clinic in India
- Implications and barriers for long COVID
- Reducing risk of impact of long COVID
- Managing long COVID



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Further information:

Panellists will include:



- **Dr Sarah Ali**, Consultant in Endocrinology, Royal Free London NHS Foundation Trust



- **Dr Amitava Banerjee**, Associate Professor in Clinical Data Science and Honorary Consultant Cardiologist, University College London



- **Dr Nishreen Alwan**, Associate Professor in Public Health for Medicine at the University of Southampton



- **Dr Shashank Joshi**, Dean Indian College of Physicians ICP (Academic wing of the API) Covid task force key member for the Maharashtra State, Consultant Endocrinologist, Lilavati Hospital Mumbai

Register:

TO REGISTER FOR THIS SEMINAR CLICK HERE OR GO TO:

https://zoom.us/webinar/register/WN_eVDEk1QrTfyLCm-TxqtrYg

If the Zoom webinar has reached capacity, you can also watch a livestream of the webinar on YouTube at: <https://www.youtube.com/c/AHSNNetwork/live>

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Thank you