Palliative Care Guidelines for COVID - Part 2

Guidance for Palliative, Hospice and Bereavement Care for COVID-19 and other Patients facing Life-Threatening Illness in Hospitals

18 May 2020 (Provisional Draft)

Prepared by

Philippine Society of Hospice and Palliative Medicine (PSHPM)

and

Hospice Philippines

through the support of

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Contributors

Agnes Bausa-Claudio, MD, FPSHPM, MPH
Head of Palliative and Supportive Unit (PASCU), Jose B Lingad Memorial Regional Hospital (JBLMRH), Amang Rodriguez Memorial Medical Center (ARMMC); Past President, National Palliative and Hospice Care Council of the Philippines; Founding Board and Advisory Council, Philippine Society of Hospice and Palliative Medicine (PSHPM); Medical Director, ActivCare Home Health Solutions

Maria Fidelis Manalo, MD, MSc.
Head, Section of Supportive Oncology & Palliative Care, Augusto P. Sarmiento Cancer Institute, The Medical City; Consultant & Faculty, Department of Community & Family Medicine, FEU-NRMF; Founding Member, Philippine Society of Hospice & Palliative Medicine

Rumalie Alparaque-Corvera, MD, DPAFP, FPSHPM
Vice Chairman, Department of Occupational and Family Medicine, Asian Hospital and Medical Center; Advisory Council, Philippine Society of Hospice and Palliative Medicine and National Palliative and Hospice Care Council of the Philippines; Executive Director, The Ruth Foundation for Palliative and Hospice Care

Rojim Sorrosa, MD, FPAFP, FPSHPM
Consultant, Southern Philippines Medical Center (SPMC);
Faculty, Davao Medical School Foundation, Inc. College of Medicine;
Board Member, Philippine Society of Hospice and Palliative Medicine (PSHPM)

Philline Salvador, MD
Consultant, Alliance for Improving Health Outcomes (AIHO), Kalusugan ng Mag-Ina (KMI) and Philippine Society of Public Health Physicians (PSPHP)

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Background

One of the challenges and realities posed by the current health emergency posed by COVID-19 is the speed at how patients can get into severe conditions and eventually reach death. Most health professionals do not have adequate knowledge and capacity on how to prepare and communicate with patients and their families, who are facing the uncertain course of this illness. There are clinical measures and holistic interventions that can be done for the provision of palliative care services, most especially for patients in the severe and refractory stages of the infection.

Using our current knowledge in palliative care, we want to support our colleagues in hospitals and communities in managing patients and their families who need palliative, hospice and bereavement care. This provisional guidance document was developed by the Philippine Society of Hospice and Palliative Medicine (PSHPM) in collaboration with the National Hospice and Palliative Care Council of the Philippines (Hospice Philippines) and the Philippine Society of Public Health Physicians (PSPHP).

Purpose of this Guidance Document

This guidance document aims to provide information to physicians, nurses, allied health professionals and hospital officials to adequately support the physical, social, psychological and spiritual needs of patients who are severely sick or at the end of their lives due to COVID-19 or other life-limiting diseases during a pandemic. It also aims to guide health care workers in supporting the well-being of the patient's families and close relations throughout the course of illness. This document intends to supplement previously released guidelines on the management of COVID-19 by incorporating palliative and hospice care services.

Who should use this Guidance Document?

This guidance document is especially prepared for physicians, nurses and officials in level 1 and level 2 private or public hospitals. These are recommendatory guidelines coming from experts in

palliative and hospice care using the best evidence and practice in the current public health emergency.

Hospitals, provinces and cities may use or adopt these recommendations based on their setting, context, capacity and organizational arrangements.

What are Palliative, Hospice and Bereavement Care Services?

- Palliative Care works together with the primary treatment being received. It involves complex decision-making in the effective symptom control and promotion of quality of life to provide holistic care of the physical, psychological, social and spiritual health of patients, their families and close relations; especially for populations most at risk (the elderly, severely ill and with co-morbidities),who are less likely to survive in the next 6 months to 1 year due to poor prognosis from pre-existing health conditions or those who may die due to complications from COVID-19 infection.
- Hospice Care is palliative care focusing on the pain, symptoms, and stress of serious illness during the refractory or terminal phase of illness. This care is provided by an interdisciplinary team who provides care encompassing the individual patient and their family's holistic needs. This also includes discussion and review on advance care planning topics and how these preferences are communicated in order to ensure a comfortable and dignified death, particularly when the illness is refractory to treatment.
- Assisting the patients and their families and relations in their experience of grief and bereavement.

Special considerations are made because of the challenges posed by management of patients with COVID-19 wherein restrictions for contact are put in place to mitigate the risk of further transmission of the disease patient's relations as well as the health care workers caring for the patient. There are also difficulties in decision-making when health care resources and facilities are exhausted beyond capacity. These recommendations and modifications should be considered which include:

- Remote interactions for conversations sharing clinical and prognostic information, decision-making, and supporting families in this time
    - Support honest conversations about the goals of care and treatment escalation planning as early as possible in order to develop and document personalised care and support[1]
- Guidance for complex decision-making for when health care resources and facilities are exhausted beyond capacity.

Interdisciplinary Team

Palliative and Hospice Care requires a team from different disciplines. On the clinical and care side, the core team is composed of the palliative care physician and nurse, with extended team members such as the social worker or counsellor and physical therapist. Support team should include social services, spiritual advisors, psychosocial support, logistics and supplies and family support. Health professionals should always check that the family has access to these different types of services and support.

Optimizing Hospitals for Provision of Palliative Care in Pandemics

Summary of Palliative Care Pandemic Plan

Stock	Staff	Space	Systems
● Stockpile medications for common symptoms ● Prepare kits including medications and equipment to deliver medications for long-term care facilities and home care services.	● Identify all clinicians with palliative care training and exposure: Physicians, Nurse specialists ● Provide focused education sessions to frontline staff for symptom management and end-of-life care for COVID-19 patients. ● Develop standardized order sheets and protocols for symptom management and end-of-life care for COVID-19 patients. ● Involve specialist allied health care	● Identify wards and nonclinical areas in all health care facilities that would be appropriate to accommodate large numbers of patients expected to die. ● Maximize the use of identified palliative care unit, hospice, and ward beds.	● Create a triage system to identify patients in need of specialist palliative care management. ● Create a triaging system for interfacility, interfacility, and community transfers to dedicated palliative care units, hospices and wards. ● Create a system for direct consultation support for staff in hospitals, long-term care facilities, and the community by telephone or telemedicine. ● Ensure that all

	workers to provide psychosocial support and grief and bereavement counseling. ○ social workers ○ spiritual care staff		patients currently admitted to health care facilities have clear and updated advance care plans.

Source: Downar, James et al. (2010)[2] ; Clark et al (2020)[3]

For Stable Patients in whom COVID-19 is Suspected or Confirmed

Discussions about Goals of Care

- Advanced Care Planning
    - ensure timely open honest conversations about patient's preferences and priorities, treatment escalation, prognosis, including advance decisions to refuse further treatment
        - There may be emergency or urgent situations, wherein health professionals may have to triage patients and prioritize particular interventions and ceilings of treatment. This is not only to ensure that those with significant potential to recover receive appropriate care, but also that those who are very unlikely to survive also receive appropriate, end of life care.
    - explain likelihood of the disease becoming more severe with a tendency for rapid clinical deterioration which may consequently limit the opportunities for discussion and involvement in decision-making.
    - develop and document a personalized care and support plan to be revisited and revised as the situation changes
    - involve patient's families and close relations in these discussion as far as possible while considering the patient's personal wishes
        - consider that families and close relations may be overwhelmed by the possible quick turn of events throughout the course of illness and may need assistance in processing these events
        - consider that the patient's carer, members of the family and close relations may themselves be ill and/or required to self-isolate
        - consider use of telephones and other means of telecommunications to conduct these conversations

    - in these instances, maintaining open, honest and clear communication helps reduce anxiety even as health care professionals may not have all the answers
- Pointers to consider when discussing goals of care/ceiling of treatment. The following framework (SPIKES) may be used as a guide (See below).
- Be prepared to handle negative emotions (anger, upset, questions). React professionally, even if they are difficult at the time.
- Ensure adequate protection of the health care workers at all times throughout the care of all suspected and confirmed cases of COVID-19 and their families by provision of PPEs, training in their adequate donning and doffing, strict observance of IPC measures and hand hygiene.
- Ensure psychosocial support is available for healthcare workers supporting care for these patients.

Setting / situation	Read clinical records, ensure privacy, no interruptions *"How are you related to the patient? Some people like to bring someone who is close to them. Is there anyone else you would like to be here with you while we talk?"*
Perception	What do they know already?; make no assumptions *"What is your understanding of your health situation and what is likely to happen?"*
Invitation	How much do they want to know? *"Often people with conditions like yours have got a lot of questions that are sometimes scary, or sometimes they're not certain if they want to know the answer. Often the thing they fear or believe is worse than how it really is. So if there's anything you want to know, feel free to ask me and I'll answer as best as I can."*
Knowledge	Explain the situation; avoid jargon; take it slow; use words that can be understood by the patient and his/her relations *"I want to talk about three things today: the test results; what this will mean for you; and the treatment that is possible. Doctors sometimes forget and use words that may not be understood. Please interrupt me if I am doing this."*
Empathy	Even if busy, show that you care; be mindful of pace and tone; use silences to allow processing of information

	"I can see how upsetting this is to you." You seem to be afraid and worried. Please tell me more.
Summary / strategy	**S**ummarise what you've said; explain next steps "These are very challenging times. Rest assured that we will all be here for you. Our team will do the best we can to help address your needs. Please feel free to communicate to use anytime."

Source: Lawrie (APM, 2020)[1], KERALA Task Force in Palliative Care (PallicovidKerala) 2020[4] ,

Management during the severe and refractory phase of illness

Setting up support for family caregivers

- Ensure the patient understands the role and services of palliative care.
- Ensure the patient decides who will be his/her primary and back-up family caregiver and the level of involvement in his/her care.
    - If the patient is not mentally competent to identify his/her family caregiver, the physician must be able to determine the structure of the family using a simple genogram. Key decision makers and next of kin should be identified.
- Explain to the appointed care-givers their roles and responsibilities on how to care for their loved one suffering from COVID-19. Concerns about their caregiving role should also be discussed.
- Discuss to the patients and family caregiver(s) the options and implications (including legal implications) of advance care planning.
- Establish realistic expectations with the family caregiver(s) on what palliative care services can provide.
- If the patient is not mentally competent to identify his/her family caregiver, the physician must be able to determine the structure of the family using a simple genogram. Key decision makers and next of kin should be identified.

Assessing need and establishing a plan of care

- Whenever possible, convene family caregiver(s) including the patient, if practical, provided that safety precautions are observed, to discuss the needs, goals of care, site of care and referral requirements.

- Determine the needs of the patient and his/her family which should include psychological and physical health, social, spiritual, cultural, financial and practical elements and create a plan how these needs can be addressed.
- Determine the current state of and risk of poor psychological health and/or prolonged grief of the family caregiver(s) and other family members and plan for relevant intervention(s).

Management of common symptoms arising from infection with COVID-19 and in the phase of any illness refractory to treatment

These guidelines assume that the patient is receiving all appropriate supportive treatments and that correctable causes of the symptoms have been considered and managed appropriately.[1,4] Examples:

- fever, cough, breathlessness and delirium may improve with antibiotic treatment for a superimposed bacterial infection
- cough and breathlessness may improve by optimising treatment of comorbidities (e.g. chronic obstructive airways disease, heart failure).

They are described in terms of the severity of the disease and adopt the general approach of:

- correcting the reversible causes appropriately
- non-pharmacological approaches - generally preferred, particularly for mild to moderate disease
- pharmacological approaches - may be necessary for distressing symptoms, particularly in severe disease.
    - Typical starting dose and frequency of medications are provided. However, these may need to be adapted to specific patient circumstances, e.g. frail elderly (use even lower doses of morphine), or renal failure (use an alternative to morphine), available drugs and knowledge and practice of healthcare providers
    - Seek appropriate advice from the relevant specialists including specialist palliative care teams.

It is anticipated that critically ill patients with ARDS will be mechanically ventilated and be receiving some level of sedation ± strong opioids. Death may still ensue from overwhelming sepsis or organ failure. If endotracheal extubation is planned in a dying patient, teams should follow their own guidelines on withdrawal of ventilation. A team approach is best to establish a decision about medical futility. An example of this scenario is when all medical measures have been undertaken but the patient further deteriorates. Team discussion can be done using a formal meeting approach or through the use of technology like telemedicine.

Symptom	**Management**
Dyspnea and/ or Pain	T*reatment of underlying causes of dyspnoea should be considered and optimised where possible.* **Nonpharmacologic measures** ***Dyspnea*** ● positioning (if not on invasive ventilation: sit upright, legs uncrossed, let shoulders droop, keep head up; lean forward with arms bracing a chair or knees and the upper body supported) ● pursed-lip breathing - advise the patient to inhale through his nose for several seconds with their mouth closed, then exhale slowly through pursed lips for 4 to 6 seconds. ● relaxation techniques ● reduce room temperature ● cooling the face by using a cool cloth ● avoid use of portable fans during outbreaks of infection or when a patient is known or suspected to have an infectious agent. Although there is no strong evidence yet, it has been linked to cross infection in health and social care facilities. **Pharmacologic Measures** ● Drug of choice: (hold if RR < 12/min) ○ Morphine sulfate 10mg/mL, 2 mg IV q 30 mins, until there is adequate control of respiratory distress (RR<20/min) or pain (VAS 5/10) and give that dose q4h RTC and as rescue dose q1h; OR ○ Fentanyl citrate 0.05mg/mL, 12.5-50 mcg IV q 15 mins until there's adequate control of respiratory distress (RR<20/min) or pain (VAS 5/10) and give that dose q4h RTC and as rescue dose q1h ■ preferred if creatinine > 2mg/dl ● Anxiety due to dyspnea (synergistic): ○ Midazolam 5mg/5mL, 2 mg IV q4h (2 hours apart from opioids); ■ Hold if BP <90/60mmHg. OR ○ Diazepam 2mg PO every 8 hours +/- 5-10 mg nocte ● Ensure regular bowel movement. Laxatives should be given for opioid-induced constipation. ○ Bisacodyl 10 mg/tab PO at bedtime on the same day of starting morphine

	● May start an antiemetic if indicated ○ Metoclopramide 10 mg q8h OR Haloperidol 0.5 - 1 mg daily for the first 3 days of opioid therapy * Haloperidol is more suitable in patients with agitation For severe respiratory distress or pain ● Start opioid drip: (Hold if RR <12/min) *In patients with normal creatinine clearance* ○ Morphine sulfate 10mg/mL, 100mg in 90 ml plain NSS to run at 5mg/hr (5 ml/hr); titrate upwards by increments of 50% current dose until there's adequate control of respiratory distress (RR<20/min) or pain (VAS 5/10) and maintain at that dose. ○ May still give rescue doses of Morphine sulfate 5mg IV (or whatever is the current drip rate) q1h for breakthrough dyspnea or pain; OR *In patients with Acute Kidney Insufficiency/CKD* ○ Fentanyl citrate 500mcg/10mL, 1000 mcg in 80 ml plain NSS to run at 50 mcg/hr (5 ml/hr); titrate upwards by increments of 50% current dose until there's adequate control of respiratory distress (RR<20/min) or pain (VAS 5/10) and maintain at that dose. ○ May still give rescue doses of Fentanyl citrate 50 mcg IV (or whatever is the current drip rate) q1h for breakthrough dyspnea or pain.
Pain	Pain may be due to existing comorbidities or result from excessive coughing or immobility and should be addressed using existing approaches to pain management. **Patient on no analgesics - mild pain** ● Step 1: ○ start paracetamol 500 mg every 6 hours, and adjust up to maximum dose of 4 grams in 24 hours (start low and go slow) ○ dose reduction is advisable in old age, renal impairment, weight <50kg, etc ● Step 2: ○ persistent or worsening pain: stop paracetamol if not helping pain ○ consider use of tramadol for moderate pain ● Step 3: ○ maximum paracetamol for persistent or worsening pain: stop

paracetamol if not helping pain
- commence opioid (e.g. oral morphine)

Commencing Strong Opioids

- For acute pain crisis, consider starting intravenous morphine as soon as possible at a dose of 1 to 2 mg every four hours. If otherwise, start immediate-release (IR) morphine at a dose of 2.5 to 5mg every 4 hours around the clock.
- Once morphine is given as RTC medication, always provide a standing order for severe breakthrough pain episodes to be given on a PRN basis. The dose for breakthrough pain should be at least 10-20% of the total dose of morphine in 24 hours.
- Starting dose will depend on existing analgesia – calculate dose required
- Monitor the patient closely for effectiveness and side effects
- Always prescribe laxatives alongside strong opioids
- Always prescribe an antiemetic regularly or prn

Suggested starting doses

- Opioid-naïve/frail/elderly
  - morphine 2.5-5mg PO IR 4 hourly
- Previously using regular weak opioid
  - morphine 5mg PO IR 4 hourly or MR 20-30mg BD
  - frail/elderly: use lower starting dose of 2.5mg PO IR 4 hourly or MR 10-15mg BD
- eGFR <30
  - seek advice

Advice for pain control[5, 6]

1. Pain control, side effects, total amount of morphine and number of rescue doses in the last 24 hours should be assessed and monitored on a daily basis.
2. If the background pain is uncontrolled in the last 24 hours to 48 hours, titrate by increasing the regular morphine dose requirements by 30-50%.
3. Increase the rescue dose accordingly.
4. Upward titration of the dose of morphine stops when either the pain is controlled or intolerable undesirable effects supervene.
   - If the pain is controlled for 24 to 48 hours with the use of regular or immediate release morphine, convert to the same total daily dose using modified release morphine.
   - If the patient experiences undesirable effects, contact or refer to a local palliative care specialist provider for further

	advice. 5. If the side effects are tolerable, treat using pharmacologic and non-pharmacologic interventions. 6. Daily monitoring for morphine toxicity and overdosage. 7. If adequate pain control is not achieved in 48 hours, contact or refer to a palliative care specialist for further advice. Titrating oral opioid dose ● If adjusting the dose of opioid, take prn doses into account ● Check that the opioid is effective before increasing the dose ● Increments should not exceed 30-50% every 24 hours ● Titration of the dose of opioid should stop when either the pain is relieved or unacceptable side effects occur ● If pain control achieved on IR consider conversion to MR opioid (same 24-hour total dose) ● Seek specialist advice if analgesia titrated 3 times without achieving pain control / 3 or more prn doses per day / total daily dose of oral morphine over 120mg / day unacceptable side effects **When the oral route is not possible** ● If analgesic requirements are stable, consider transdermal patches (e.g. buprenorphine, fentanyl) ● If analgesic requirements are unstable, consider initiating subcutaneous or intravenous opioids ● Seek specialist advice if necessary ● Morphine is recommended as the first line strong opioid for subcutaneous use for patients, except for patients who have been taking oral oxycodone or those with severe renal impairment ● If constant pain, prescribe morphine 4 hourly SC injections or as 24-hour continuous infusion via a syringe driver (McKinley T34) ● Conversion from oral to SC morphine: oral morphine 5mg ≈ SC morphine 2.5mg ● Wide inter-individual variation exists and each patient should be assessed on an individual basis ● Prn doses of 1/10 to 1/6 of regular 24-hour opioid dose should be prescribed 2-4 hourly SC prn References for pain: Hendin et al (2020)[7]
Fever	**Non-pharmacologic measures** ● reduce room temperature

● associated signs and symptoms: shivering, shaking, chills, aching muscles and joints, other body aches	● wear loose clothing ● cooling the face by using a cool flannel or cloth ● oral fluids ● avoid alcohol ● avoid use of portable fans during outbreaks of infection or when a patient is known or suspected to have an infectious agent. Although there is no strong evidence yet, it has been linked to cross infection in health and social care facilities. **Pharmacologic Measures** ● Paracetamol 500mg PO / IV / PR every 6 hours (Max dose of 4g in 24 hours) ○ if a patient is close to the end of life, it may be appropriate to consider use of NSAIDs (although evidence about it's safety is uncertain) (e.g.ibuprofen 200 - 400mg TID PRN) ○ Adjust doses for renal impairment
Agitation/ Delirium ● acute confusional state (that is a sudden change over a few hours or days, varying at different times of day) that can happen when someone is ill ● may manifest as confusion, unusual behavior, agitation, or withdrawal	Prevention of delirium is better than cure, so meticulous adherence to delirium prevention strategies (orientation, prevention of constipation, management of hypoxia, etc) is essential. Adoption of daily screening, using Single Question in Delirium (SQiD) and / or 4AT rapid test for delirium (https://www.the4at.com/) may be used to detect early and treat the cause. **Non-pharmacologic Measures** ● 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 **Pharmacologic Measures** ● Midazolam 2mg IV q4h prn (2 hours apart from opioids); OR ● Haloperidol 2.5mg IM stat and 2.5mg SC q4h, prn *Distressing Agitation (Palliative Sedation):*

	● Midazolam drip 15mg/3mL, 30mg in 24 ml plain NSS to run at 2mg/hr (2ml/hr); titrate upwards by increments of 1mg/ml until agitation is adequately controlled and maintain at that dose. ● NOTE: Hold if BP<90/60mmHg, resume once BP normalizes
Airway secretions	● Hyoscine-n-butyl bromide 20mg/ml, 20mg IV q6- q8h as antisecretory agent to minimize secretions. ● Minimize suctioning.
Cough	**Cough Hygiene** To minimise the risk of cross-transmission: ● cover the nose and mouth with a disposable tissue when sneezing, coughing, wiping & blowing the nose ● dispose of used tissues promptly into clinical waste bin used for infectious or contaminated waste ● clean hands with soap and water, alcohol hand rub or hand wipes after coughing, sneezing, using tissues, or after contact with respiratory secretions or objects contaminated by these secretions **Nonpharmacologic Measures** ● humidify room air ● oral fluids ● honey and lemon or ginger in warm water ● suck cough drops or hard sweets ● elevate the head when sleeping ● avoid smoking **Pharmacologic Measures** ● Butamirate Citrate 50mg PO 8-12hourly for dry non-productive cough ● Levodropropizine 30mg PO 8hourly ● Morphine sulphate 2.5 - 5 mg PO every 4 hours (may increase up to 5 - 10 mg every 4 hours as required) If all these measures fail, seek specialist advice to discuss: ○ use of oral corticosteroids ○ use of bronchodilators ○ if severe and refractory morphine sulphate injection 10mg CSCI over 24 hours and 2.5–5mg SC 4 hourly PRN

References: Adapted from Twycross R (2003)[6] and WHO (2013)[8]

Avoid the use of the following that may generate aerosolized SARS-COV2 virus particles and infect healthcare workers and family members:

- Fan
- High-flow nasal cannula oxygen
- Continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BiPAP)
- All nebulized treatments (bronchodilators, epinephrine, saline solutions etc).

Withdrawal of Life Sustaining Therapy

- There will be instances where decisions will be made to withdraw life sustaining therapy such as mechanical ventilation.
- Given that extubation is considered an aerosol generating procedure and thus can be high risk to health care workers and family members present in the room, our recommendation is to not extubate the patient in the Emergency Department, but to decrease ventilatory support and ensure comfort throughout.
- If extubation is being considered, the patient should be in a negative pressure room and all providers should be prepared with airborne personal protective equipment.
- Prior to this, we recommend speaking with experts in Critical Care and following best practices for withdrawal of mechanical ventilation.
- Make sure comfort measures such as administration of opioids, benzodiazepines, and anti-cholinergic drugs are being done to adequately control dyspnea/pain, agitation, and secretions. Refer to specialist palliative care as needed.

Provision for appropriate integrative approaches

Consider the patient's level of functionality and communication resources and use of PPE's during bedside teaching or demonstration.[9]

Cognitive modalities	**Spiritual Care**	**Physical modalities**
● Distraction training ● Relaxation training ● Active coping training ● Graded task assignments, setting goals, pacing, prioritizing ● Cognitive behavioral	● Chaplaincy Care ● Meditation and/or prayer ● Spiritual/existential counseling ● Referral to spiritual care or pastoral psychotherapist	● Bed, bath, walking supports ● Positioning instruction ● Instruction in therapeutic and conditioning exercise ● Energy Conservation

therapy, cognitive restructuring ● Behavioral activation		

For Other Patients

- Use existing local or institutional palliative care guidelines.
- Ensure access to care

Working within a Multidisciplinary Team

Improving the quality of care for all patients facing severe and complex illness also requires efforts to increase information sharing while maintaining appropriate and ethical communication between all physicians directly caring for the patient and his/ her family.[10] The timely and regular interaction will help the physicians develop collaborative practices which can facilitate the alignment between potential differences in professional perspectives among the members of the attending team. In this context, the following factors have been identified to facilitate patient-centered multidisciplinary care:

1. Optimal Inter-professional collaboration and coordination.
2. Increasing interaction opportunities between attending doctors (e.g. medical case meetings, hospital case conferences)
3. Increasing interaction opportunities of multidisciplinary team with patient and family (family meetings)
4. Improving institutional framework for communication.
5. Encouraging a sense of mutual understanding rooted in the shared goal of best quality of life for the patient.

Advance Directives

These Guidelines are based on Interim Guidelines of the Philippine Society for Microbiology and Infectious Disease (PSMID).[11]

1. The free and informed decision not to resuscitate made by a competent patient through an advanced directive should be followed.
2. Without the patient's advanced directive, the free and informed decision of an appropriate proxy of an incompetent patient should be followed.

3. Without a patient's advanced directive, the medical team can make the decision based on futility, the best interest of the patient, and scarcity of resources.
    a. The medical team may withhold cardiopulmonary resuscitation on critically ill patients with NO reasonable chance of recovery: these include COVID-19 Acute Respiratory Distress Syndrome secondary to High-Risk Pneumonia not responding to treatment, refractory septic shock, or multi-organ failure.
4. Efforts must be made to provide spiritual care and counseling for the patient and family.

The Dying Process and Immediately After Death

Preparing for death

- Provision of anticipatory guidance should be ensured so as to prepare the family caregiver(s) for the patient's imminent death
- Families need to be aware of the over-all goals of care for the imminently dying patient
- Appropriate psychosocial and spiritual care should be offered

For Patients in whom COVID-19 is suspected or confirmed.

- Utmost consideration and care must be given to the safety of other patients, visitors and staff by maintaining infection control procedures at all times
- Inform and support family and/or next of kin
- Appropriately trained professional completes Verification of Death process wearing required PPE and maintaining infection control measures
- Where next of kin / possible informant are following self-isolation procedures, arrangements should be made for an alternative informant who has not been in contact with the patient to collect the Medical Certificate of the Cause of Death and attend to give the information for the registration

Bereavement support

- Ensure communication to the health care team is prompt following a patient's death.
- After the patient's death, a member of the health care team should contact the family caregiver(s) to offer condolences and answer questions of the family.

- Develop a bereavement care plan with the family based on the needs of the family, the pre-death risk assessment and the circumstances of the death.
- Access to grief and bereavement support programs should be explored if local resources permit
- Contact the family caregiver(s) and other family members to assess their need at three to six weeks post-death and adapt the bereavement care plan accordingly.
- Conduct a follow-up assessment of the family six months post-death to review possible symptoms of prolonged grief and other psychosocial health problems.

Legal and Social Support

The hospital medical records is in charge of patient records and the issuance of the medical certificate. These forms are then submitted to the city health office and the local civil registrar. In cases where a patient dies at home, the LGU, the Municipal Health Office and Barangay Officials will have protocols on how these legal documents are issued.

Under Universal Health Care, government hospitals can already provide many health services for free and through PhilHealth benefits. Much of the healthcare costs in private hospitals may even be supported by PhilHealth. Families may also be referred to social welfare of the hospital and local governments for social services. Depending on the locality, benefits and aid may be provided.

Spiritual and Religious Aspects

Most Filipino families have a strong faith in God and have specific beliefs in death and afterlife. Feel free to discuss with the family regarding their faith and religious involvement. Normally, their local religious leaders or workers may visit them at home or in the hospital. In the current scenarios, such arrangements may be limited. Video conferences or phone calls may be the best option. Hospitals may also have chaplain, pastor, priest or religious workers available for counselling and spiritual briefing.

Funeral Arrangements During COVID Enhanced Community Quarantine

The current scenario requires special arrangements for burial/ cremation of patients who die with confirmed COVID infection. Families and hospitals are advised to follow national guidelines in immediate cremation within 24 hours, and with a limited number of family members to attend to the deceased. Funeral homes and churches have likewise prepared arrangements for funeral rites. Physicians and health professionals should be able to provide this advice to families.

For Further Assistance

Clinical Practice Guidelines, DOH Advisories and other Guidance Documents may be accessed at http://www.palliativecolab.com/

PSHPM, Hospice Philippines and The Ruth Foundation may be reached through this hotline for inquiries and concerns: 09063141421 Globe or (02) 8938-0069 PLDT mobile landline

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DISCLAIMER

This is a Provisional Guidance Document. In the context of COVID Emergency Response, this is being developed and disseminated among members of PSHPM, PAFP, PSPHP, AMHOP and other medical professionals as a guide/ reference to assist in decision-making, setting of local care systems and primary care. For more specific clinical or public health guidance, users are advised to refer to guidelines issued by DOH, hospitals and professional societies. For further concerns, questions and inquiries, you are advised to call PSHPM-Hospice Philippines Hotline at **09063141421 Globe or (02) 8938-0069 PLDT**

mobile landline. This Provisional Guidance Document will be updated as soon as new recommendations become available.

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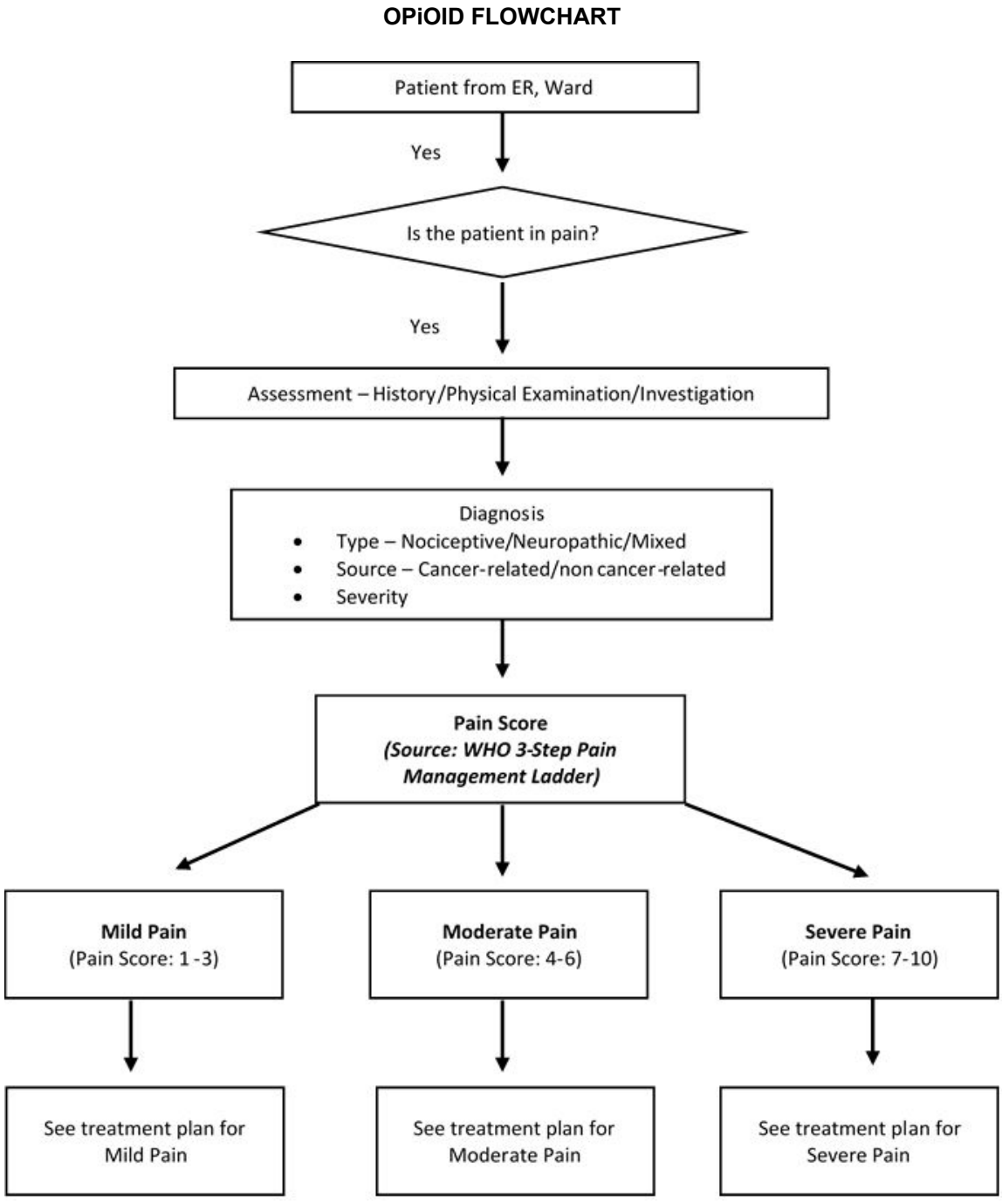
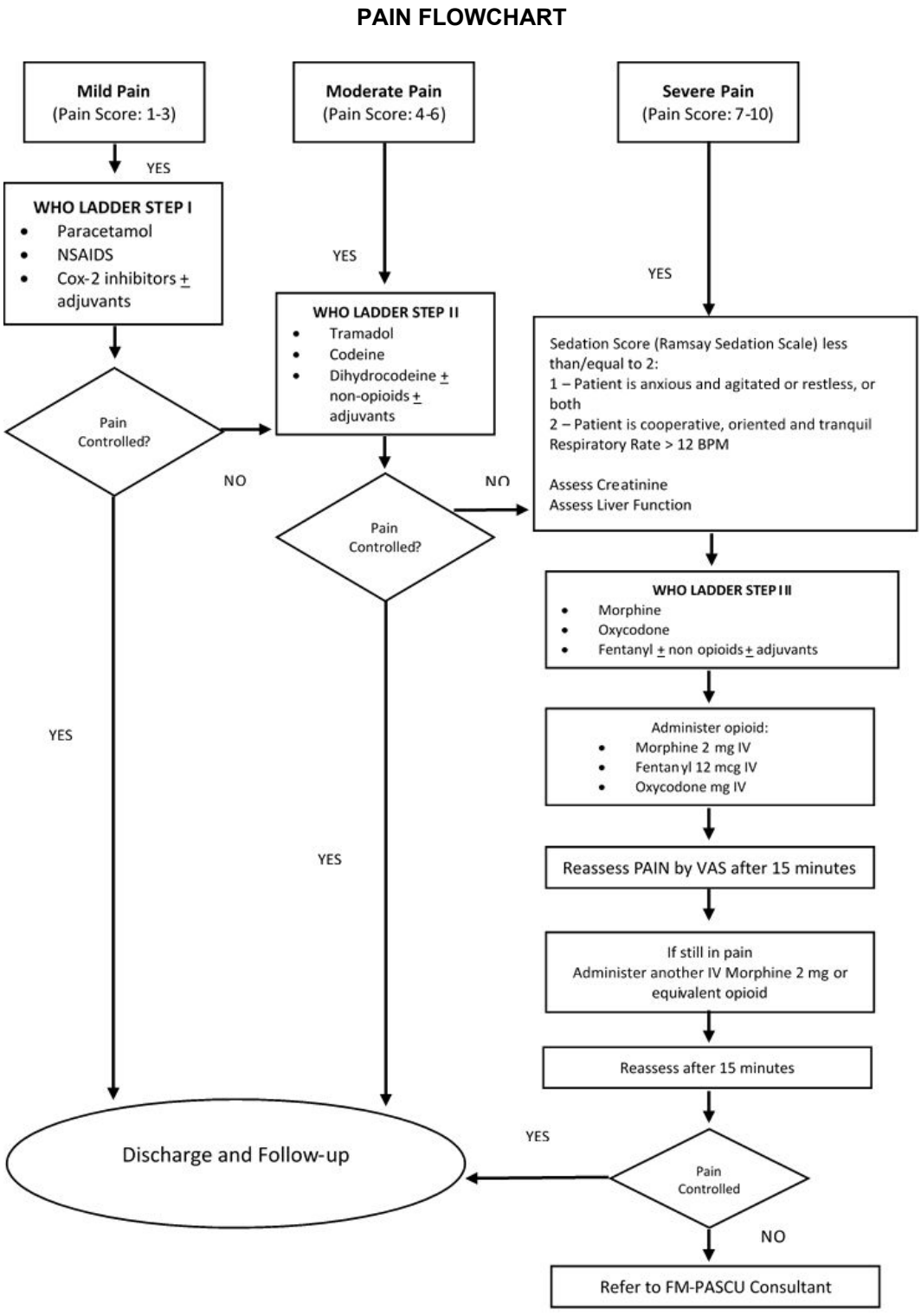
Annexes

Annex A. Opioid Management



Source: PASCU Guidelines of Jose B Lingad Regional Medical Center, San Fernando, Pampanga

Annex B. Pain Flowchart



Source: PASCU Guidelines of Jose B Lingad Regional Medical Center, San Fernando, Pampanga

Annex C. Recommendations for conservstive and palliative care management of COVID 19 patients

Emergency Palliative Care in Action (Fusi-Schmidhauser et al) Table 1

Phases of Illness	Monitoring	Drugs for symptom control
Stable: **EWR1: < 7** **RR: < 25/min** **O2 Sat: >88%** **(with Venturi mask up to 60%)**	• **3D** assessment and vital signs once per shift • Evaluate pressure & need for pressure relieving mattress • Intensify communication with the family and prepare that sick enough to die	**Dyspnea/pain**: Morphine orally 2-5mg, 4 hourly with rescue doses (10% of the total daily dose) or PRN **Anxiety**: Lorazepam sublingual 1-2.5 mg, 8 hourly or PRN or Levomepromazine PO 7.5 mg PRN **Fever**: Paracetamol PO 1 g or rectal mg, 6 hourly or PRN **Shivers**: Morphine 2-5 mg PO PRN or Pethidine 25 mg SC PRN Prescribing in Renal Insufficiency and opioids: choose Hydromorphone (accordingly to palliative care consultation) Temporary de-prescribing of usual drugs
Unstable: **EWR1 > 7** **RR: 25/min** **O2 Sat: <88%**	• **3D** assessment twice per shift if patient alert • O2 delivery max. 4 L • Observe respiratory effort • Inform the family now terminal and propose visit	**Dyspnea/pain**: Morphine IV/SC 5 mg, 4 hourly with rescue doses (10% of the total daily dose) or PRN **Anxiety/delirium/distress**: Diazepam 2.5-5 mg IV or rectal 10 mg 8-12 hourly with rescue doeses PRN or Chlorpromazine 12.5 – 25 mg IV PRN or Levomepromazione 6.25-12.5 mg SC PRN **Fever**: Dicofenac 75 mg IV PRN (max BD) or Paracetamol rectal 600 mg PRN (max. 4/day) **Shivers**: Morphine 5 mg IV PRN or Pethidine 25 mg SC PRN Hydration max. 250 ml/day Suspend futile treatments
End-of-Life: **ARDS** **O2 Sat: <70%**	• **3D** assessment twice per shift if patient alert • Assess ABDT2 Once per shift if patient does not communicate • Stop O2 • Inform the family and re-evaluate for family visits • Basic care and mouth care	**Terminal dyspnea – Respiratory distress**: • Morphine IV/SC 5 mg, 4 hourly with rescue doses (10% of the total daily dose) or PRN • Diazepam 2.5-5 mg IV or rectal 10 mg 8-12 hourly with rescue doses PRN **Hyperactive delirium** • Diazepam 2.5-5 mg IV or rectal 10 mg 8-12 hourly with rescue doses PRN • Chlorpromazine 12.5-25 mg IV PRN or Levomepromazione 6.25-12.5 mg SC PRN **Fever**: Diclofenac 75 mg IV PRN (max. BD) or Paracetamol rectal 600 mg PRN (max. 4/day) **Shivers**: Morphine 5 mg IV PRN or Pethidine 25 mg SC PRN

Abbreviations:

- EWR1: Early Warning Score and Rules for 2019-nCov Infected Patients
- RR: Respiratory rate
- O2 Sat: Saturazione ossigeno
- 3D – Dyspnea, Distress, Discomfort/Pain
- Vital signs: blood pressure, oxygen saturation, pulse, body temperature

Source: Emergency Palliative Care in Action (Fusi-Schmidhauser et al) Table 1