COVID-19 Palliative Sedation Nursing Considerations

This “Quick Tips” document is intended to support symptom management specifically for, and limited to, Adult Patients with COVID-19 infection receiving End-of-Life Supportive Care Outside of ICU. See the Provincial Palliative Sedation Clinical Knowledge Topic and Care of the Imminently Dying Clinical Knowledge Topic for all other relevant end-of-life situations.

Review COVID-19 Specific Quick Tips: Palliative Sedation.
Implement Care of the Imminently Dying Pathway and refer to the Provincial Clinical Knowledge Topic Care of the Imminently Dying (Last Hours to Days of Life), Adult (where it has been integrated).

Initiate the sedating medication(s)

- The therapeutic goal of palliative sedation for an adult patient dying from COVID-19 who requires palliative sedation for a refractory symptom is to render the patient unresponsive to stimuli (score of -5 on the Richmond-Agitation Sedation Scale (RASS) (Refer to Appendix D of the Palliative Sedation Clinical Knowledge Topic for information related to monitoring for level of sedation).

Titrate medication (dose/rate) to achieve the desired level of sedation as specified in the prescriber’s order.

- The frequency of monitoring is determined by the practice setting and individual circumstances; level of sedation should be assessed at least as often as the specified bolus/titration interval.
- There is minimal risk of respiratory depression when using medications with a short half-life and initiating at a low dose, which is titrated based on patient assessment. It is important to remember that patients receiving palliative sedation are actively dying and it is anticipated that their respirations will change as they near death; it is not a reason to decrease or stop the medication.

Assess the patient regularly for:

- **Level of sedation (RASS score);**
- **Relief of refractory symptoms;**
- **Potential adverse effects;** and
- Grimacing, restlessness, or agitation, which would indicate the need to administer a prn bolus dose of the sedating medication and/or increase the scheduled intermittent dose/infusion rate as per the prescriber’s order.

Document the administration of palliative sedation medications

- **Assessment, administration of medication, use of prn bolus dose** and **titration** of dose/rate, along with associated rationale and response (RASS score).
- Must follow practice standards within each care setting.

Version September 16, 2020 – All Zones
Amanda.lucas@ahs.ca & lorelei.sawchuk@covenanthealth.ca

Alberta Health Services

Review of Medications/Care Plan

- Ensure all life prolonging interventions (e.g. antibiotics, etc.) and all medications, which are not contributing to the patient's comfort, have been discontinued as reviewed by the Most Responsible Health Provider (MRHP).
    - The use of oxygen should be reviewed with consideration of the intent (comfort vs. life prolongation). Refer to the Rapid Response Report: Oxygen Therapy (COVID-19 Scientific Advisory Group Rapid Response Report).
- Ensure all medications necessary for comfort are ordered by a non-oral route.
- In most cases, continue scheduled analgesics and anti-emetics and discontinue all prn medications except the medication used for sedation.
- It is not necessary to check vital signs, including oximetry, when patients are receiving palliative sedation.

Physical Care

- Care of patients undergoing palliative sedation must include a focus on dignity and personhood. The care team must act as advocates for the patient and family at this time.
- Optimize interventions such as personal hygiene and frequent mouth care.
- Position appropriately to maintain a patent airway. Reposition to optimize and maintain comfort. Frequent repositioning may not be necessary or beneficial for patients who are imminently dying.
- Assess for bladder fullness and constipation as this may increase agitation.
    - Interventions for bowels and bladder should be discussed with the MRHP based on individual circumstance, comfort, and prognosis.
- Provide a private, peaceful environment.
- Do not use a fan. (May spread droplets containing COVID-19). Refer to Rapid Response Report: COVID 19 Non-invasive Ventilation Recommendations.

Equipment, supplies, initiation

- Continuous infusion (route of palliative sedation medication will depend on MRHP order and setting e.g. SC routes are typically used in non-acute care settings and IV route may already be in situ in acute care settings).
    - Continuous Infusion Pump:
        - A dedicated IV or SC line (to ensure line is used only for the one medication).
        - Medication mixed in mini bag supplied by pharmacy.
        - Alcohol swabs.
    - Two to three 10 mL syringes of normal saline with appropriate labelling for IV/SC administration.
- Intermittent administration can be used when continuous infusion not available.
    - Prepare syringe(s) of palliative sedation medication(s) as ordered by MRHP.
    - Dedicated subcutaneous injection sites (butterflies or hypodermocylsis) for SC route.
    - Alcohol swabs/syringes/filtered needles/ sharps container, etc. – obtained from pharmacy.

Infusion notes

- Give loading dose as per MRHP orders.
- Refer to bolus, intermittent and titration orders to achieve level of sedation ordered (RASS score).
- Midazolam mixed on the unit in normal saline is stable for 24 hours at room temperature and does not need to be covered if used within 24 hours.

Initiating Midazolam Continuous Infusion Procedure:

- Infusion may be SC or IV dependent on setting and prescriber's order.

Mixing Midazolam When Pharmacy is Not Available:
(Under these unique circumstances, AHS / Covenant Health Pharmacy supports the following, vs. the AHS provincial parenteral drug monograph).

- Withdraw 20mL from a 100mL IV bag of normal saline;
- Draw up two 50mg/10mL vials of midazolam (for a total of 100mg of midazolam). Have a second nurse independently double check to ensure accuracy in dosage;
- Add this 20 mLs of midazolam to the bag of 80mL of normal saline. The final concentration will be approximately 1 mg/mL noting most IV bags have an overfill of fluid. Due to potential differences in preparation methods when switching between bags prepared by nursing and pharmacy where overfill is removed, we recommend increased monitoring in the event of change in effect.

Midazolam Infusion Initiation:

- Yellow subcutaneous Saf-T-intima set
- IV line without ports to ensure dedicated line for midazolam
- Needleless connector
- Tegaderm dressing
- Portless tubing
- Alcohol swabs
- 3 mL syringe

Nursing actions:

- Prime the IV tubing with normal saline;
- Insert a dedicated subcutaneous site for midazolam preferably in the abdomen, the chest or the scapula (areas with more subcutaneous tissue are preferred, other options include the upper arms or the thighs);
- Give the loading dose (bolus) as per MRHP orders and start the infusion following that;
- Use a pump to program the infusion;
- Titrate medication (dose/rate) to achieve the desired level of sedation; and
- Be conscious of the medication bag volume to be infused, so as not to let the bag run dry and risk disrupting the infusion and the sedation level.

The infusion should NEVER be discontinued or decreased without clear instructions from the MRHP.

If a Pump is Not Available for Continuous Midazolam Infusion:

- Request the MRHP to consider prescribing intermittent subcutaneous injections, such as lorazepam or methotrimeprazine (Nozinan).
    - Ensure a dedicated subcutaneous site is inserted, preferably in the abdomen, the chest or the scapula (areas with more subcutaneous tissue are preferred, other options include the upper arms or the thighs).

Or

- Utilize intravenous (IV) tubing that has a drip chamber to allow manual calculation and control for a continuous midazolam infusion.

NOTE: in settings that may use a flow meter controlled dial infusion attachment for IV tubing, this method does not provide a precise rate flow.

Home Care/ Independent Supportive Facility Living (ISFL) Considerations

- Preferred route will depend on setting of care and resources available (i.e. medications from pharmacy, injectable or mini bag). Unlikely to have IV access. Some sites may have pumps for continuous SC infusion.
- ISFL may collaborate with palliative consultants or local home care teams for available resources and support.
- Consider EMS assistance in acute situation to initiate, and provide bolus dose: EMS Palliative End-of-Life Assess, Treat and Refer (EMS PEOLC ATR) in Home Care and ISFL. Mobile Integrated Health Community Response Team may be available for ISFL in urban areas depending on day and time. Consideration for PPE for COVID-19 +ve patients.

Home Care

- Complete Expected Death in the Home documentation.
- Explore potential available funding for private nursing supports.
- Home visit or telephone triage for patient assessment and support for caregivers recommended every day/evening.
- Teach caregivers:
    - to administer medication(s);
    - to assess level of sedation and when to call Home Care;
    - refer to Handling of Deceased persons with COVID-19 document;
    - to call Home Care when patient dies; and
    - how to dispose of medication after death.

Education and Support for Patient and Family

- Ensure patients, families, and caregivers understand the key aspects of palliative sedation explained below. It should be noted that, due to the emotional burden and stress of families at this time, key messaging often needs to be repeated. Nurses should be aware of their language and messaging to patients and families to avoid confusion or additional distress around the sedation.
    - **Purpose:** To relieve suffering and provide comfort in the final days of life by inducing and maintaining a deep state of sedation when no other options are available to control distressing symptoms. The purpose is not to hasten death, but to ensure that a natural, expected death is peaceful. The aim is not to 'shorten the road' but rather 'smooth the bumps in the road.
    - **Procedure:** The patient is given sedating medication by intermittent injection or continuous infusion. Medications will be adjusted to obtain a deep level of sedation. Procedure is not the same as for Medical Assistance in Dying.
    - **Consequences:** The patient will not be able to communicate, eat or drink and will have limited ability to move independently. Patient may become incontinent.
    - **Expected Cause of Death:** Patient will die as a result of the underlying disease, not as a result of the palliative sedation. Death may occur while receiving or soon after receiving sedating medications; however, the medications do not cause death.
- Provide opportunity for farewell and closure before initiation of palliative sedation as communication will not be possible once sedation is initiated.
- Provide ongoing emotional support to patients and families and offer additional education and support from other available services, such as spiritual care, social work, palliative consult team, and grief support, before, during, and after administration of palliative sedation.

Self-Care and Additional Supports

- Seek additional support for yourself and colleagues as required prior to and during the administration of palliative sedation.
- Review goals of treatment, as well as any ethical concerns that may arise.
- Seek opportunities for debriefing after a patient has died. This may be particularly important when practicing in the community or in a setting that is not a dedicated palliative care area.
- Support may be available from a variety of services, such as spiritual care, social work, grief support, Employee and Family Assistance Programs, clinical ethics, and palliative care consult teams.

References

- Provincial Clinical Knowledge Topic Palliative Sedation, Adult – All Locations V 1.0
- Provincial Clinical Knowledge Topic Care of the Imminently Dying (Last Hours to Days of Life), Adult - All Locations V 1.0 Palliative Sedation Guidelines from the Edmonton Zone Palliative Care Program
- Palliative Sedation Guidelines from the Calgary Zone Palliative Care Program

Amanda.lucas@ahs.ca & lorelei.sawchuk@covenanthealth.ca