Titel: Drug management in the palliative phase

EAPC Dr. Danila Valenti (EAPC), Letizia Ronchi
Date, 30 June 2022

Drug management in the palliative phase

Dr. Danila Valenti (EAPC)

NO CONFLICTS of INTEREST

2nd July 2022

- WHO DEFINITION OF PALLIATIVE CARE
- **INTEGRATING PALLIATIVE CARE ACROSS ILLNESS TRAJECTORIES AND EARLY PALLIATIVE CARE**
- SETTINGS AND WAY OF DRUGS ADMINISTRATIONS
- CORE PALLIATIVE CARE MEDICINES LIST FOR PALLIATIVE CARE
- SYMPTOMS **IN ADVANCED CANCER PATIENT**
- **DRUG MANAGEMENT IN THE PALLIATIVE PHASE D**URING THE COVID EMERGENCY IN THE LOCAL HEALTH AUTHORITY OF BOLOGNA
- CORE PALLIATIVE CARE MEDICINES LIST FOR COMMUNITY PHARMACY FOR HOME PALLIATIVE CARE
- OPIOIDS CRISIS

- TAKE HOME MESSAGE

WHO- PALLIATIVE CARE Definition – 2012

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Palliative care:

-provides relief from pain and other distressing symptoms;

-affirms life and regards dying as a normal process;

-intends neither to hasten or postpone death;

-**integrates the psychological and spiritual aspects of patient care;**

-offers a support system to help patients live as actively as possible until death;

-offers a support system to help the family cope during the patients illness and in their own bereavement;

-uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;

-**will enhance quality of life, and may also positively influence the course of illness;**

is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Integrating Palliative Care across illness trajectories

WHO 1990 – Lynn and Adamson . 2003

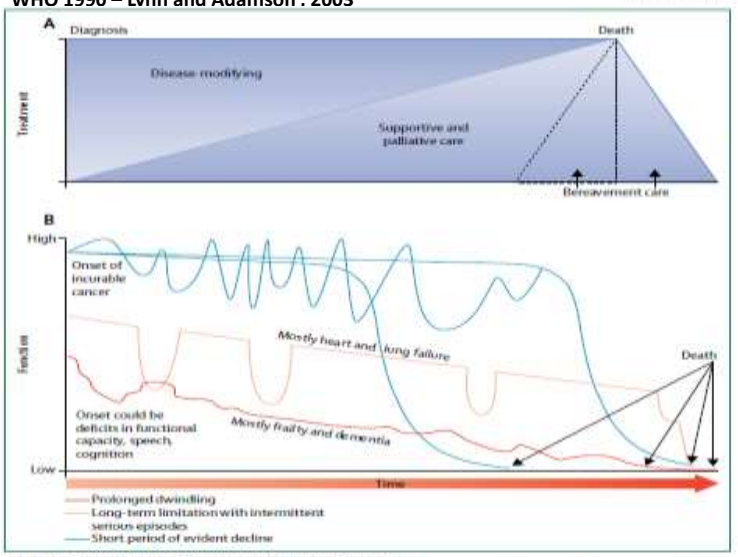


Figure 2: Integrating palliative care across illness trajectories
(A) Palliative care continuum from diagnosis to end of life. (B) Typical functional status trajectories of people with progressive chronic illness. Each line in the figure depicts a possible disease trajectory. The blue lines, for example, represent patients with cancers. For example, a patient with pancreatic cancer, with few treatment options and a low 1-year survival rate[10] is represented by the short blue line. The wavy line is more typical of a patient with metastatic cancer who can move between treatment and palliative care, with relatively high functional status, and eventually die of the disease. Source: WHO (1990),[1] Lynn and Adamson (2003).[3]

Not only End of Life!
Palliative Care is:
1) a core component of disease management,
2) integrated from point of diagnosis of a lifethreatening or life-limiting health condition,
3)growing in importance as part of comprehensive treatment
4) or end-of-life care,
5) and culminating with bereavement care

harmacy

The Lancet Commissions

Alleviating the access abyss in palliative care and pain relief— an imperative of universal health coverage: the *Lancet* Commission report

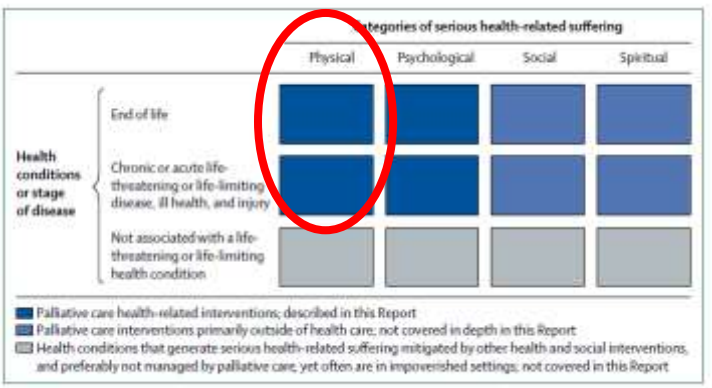


Figure 3: Serious health-related suffering, palliative care, and scope of this Report

This talk focuses on DRUGS MANAGEMENT in PALLIATIVE CARE PHASE :
(1) all health conditions associated with end-of life;
And
(2) chronic or acute, life-threatening or lifelimiting health conditions, diseases, and injuries.

This Talk does not focus on drug management on acute or chronic health conditions that are not life-threatening or lifelimiting,including chronic, non-malignant pain and does not focus on (fundamental in all palliative care phases) Psycological, Social and Spiritual Needs

Knaul FM, et al; **Lancet Commission on Palliative Care and Pain Relief Study Group**. Alleviating the access abyss in palliative care and pain relief-an imperative of universal health coverage: **the Lancet Commission report. Lancet. 2018 Apr 7;391(10128):1391-1454**. doi: 10.1016/S0140-6736(17)32513-8. Epub 2017 Oct 12. Erratum in: Lancet. 2018 Mar 9;: PMID: 29032993

SETTINGS

HOME
Not all drugs availble, different way of administration

HOSPITAL
Drugs available only at Hospital

Early Palliative Care
Outpatient/Clinic

HOSPICE

WHO ESSENTIAL MEDICINES LIST FOR PC (2017)
Acetylsalicylic acid
Amitriptylinea
Cyclizine
Codeine
Dexamethasone
Diazepam
Decusate sodium
Fentanyl (transdermal patch)
Fluoxetine
Haloperidol
Hyoscine bytylbromide
Hyoscine hydrobromide
Ibuprofen
Lactulose
Loperamide
Metoclopramide
Midazolam
Morphine
Methadone
Ondansetron
Paracetamol
Senna

Rectal administration

Intra-venous

Intramuscular injection

Oral therapy

Subcutaneous administration

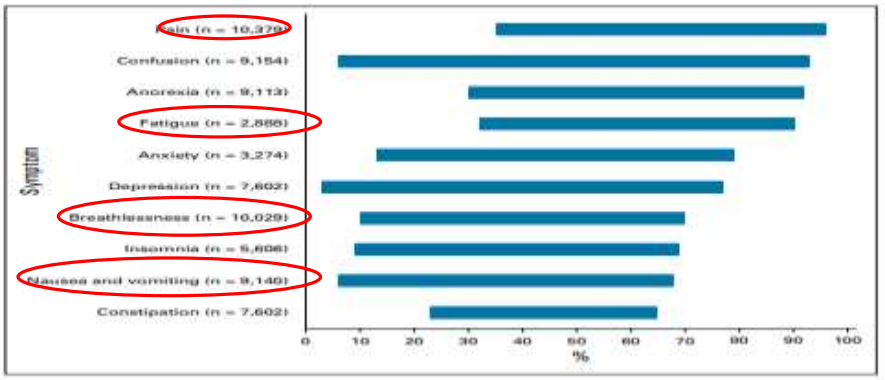
Subcutaneous administration of drugs

- ✓ **Subcutaneous administration** of drugs and fluids is **the preferred route of parenteral treatment in many palliative care settings**
- ✓ Drugs can be administered subcutaneously either as single injections, as repetitive bolus injections/ infusions through subcutaneous needles or as continuous subcutaneous infusion (CSCI) of drugs or drug mixtures delivered by mechanical pumps
- ✓ The subcutaneous treatment is easy to manage and can be practised with seemingly acceptable patient safety and tolerability in low intensive care facilities like most hospices and patients' own homes
- ✓ Marketing authorisation of many drugs used in palliative care does not comprise the subcutaneous route of administration. Consequently, **subcutaneous off-label administration often supported by recommendations in palliative literature has become an established practice in many palliative care institutions**

Jensen JJ, Sjøgren P. Administration of label and off-label drugs by the subcutaneous route in palliative care: an observational cohort study. BMJ Support Palliat Care. 2020 Sep 4:bmjspcare-2020-002185.

SPECIAL SERIES: PALLIATIVE CARE: SCIENCE AND PRACTICE

Palliative Care and the Management of Common Distressing Symptoms in Advanced Cancer: Pain, Breathlessness, Nausea and Vomiting, and Fatigue



Henson LA, Maddocks M, Evans C, Davidson M, Hicks S, Higginson IJ. Palliative Care and the Management of Common Distressing Symptoms in Advanced Cancer: Pain, Breathlessness, Nausea and Vomiting, and Fatigue. J Clin Oncol. 2020 Mar 20;38(9):905-914

Palliative Care and the Management of Common Distressing Symptoms in Advanced Cancer: Pain, Breathlessness, Nausea and Vomiting, and Fatigue

PAIN

More than 30% of patients with cancer receive inadequate analgesia for pain

Identifying the pain modality (nociceptive, neuropathic, or combined) helps direct effective therapy, with the WHO analgesic ladder providing a therapeutic framework

World Health Organization: Cancer pain relief: With a guide to opioid availability, 2nd ed.

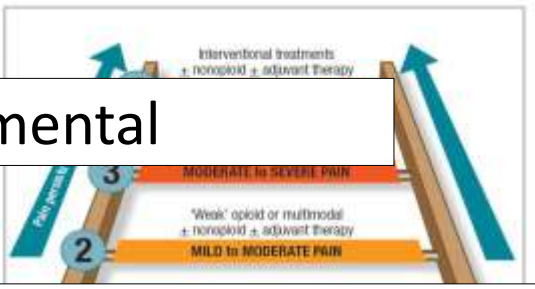
Kurita G.P. Per Sjogren P.: Management of cancer pain: challenging the evidence of the recent guidelines for opioid use in palliative care, POLISH ARCHIVES OF INTERNAL MEDICINE 2021; 131 (11) Copenhagen University Hospital, Copenhagen, Denmark

Henson LA, Maddocks M, Evans C, Davidson M, Hicks S, Higginson IJ. Palliative Care and the Management of Common Distressing Symptoms in Advanced Cancer: Pain, Breathlessness, Nausea and Vomiting, and Fatigue. J Clin Oncol. 2020 Mar 20;38(9):905-914

PAIN, **Breathlessness**

OPIOIDS are fundamental

WHAT OPIOID?



Morphine remains the first-line opioid of choice in international guidance because of its familiarity, availability, and cost .

Wiffen PJ, Wee B, Derry S, et al. Opioids for cancer pain - **An overview of Cochrane reviews.** ***Cochrane Database*** *Syst Rev.* 2017;7:CD012592.

Fentanyl and buprenorphine are recommended in renal impairment (estimated glomerular filtration rate < 30) when morphine is contraindicated. Sande TA, Laird BJA, Fallon MT. The use of opioids in cancer patients with renal impairment-a systematic review. *Support Care Cancer.* 2017;25:661–675

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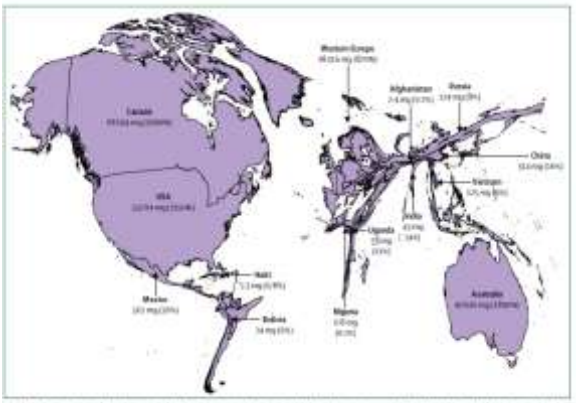
The Lancet Commissions

EAPC

Alleviating the access abyss in palliative care and pain relief—an imperative of universal health coverage: the *Lancet* Commission report



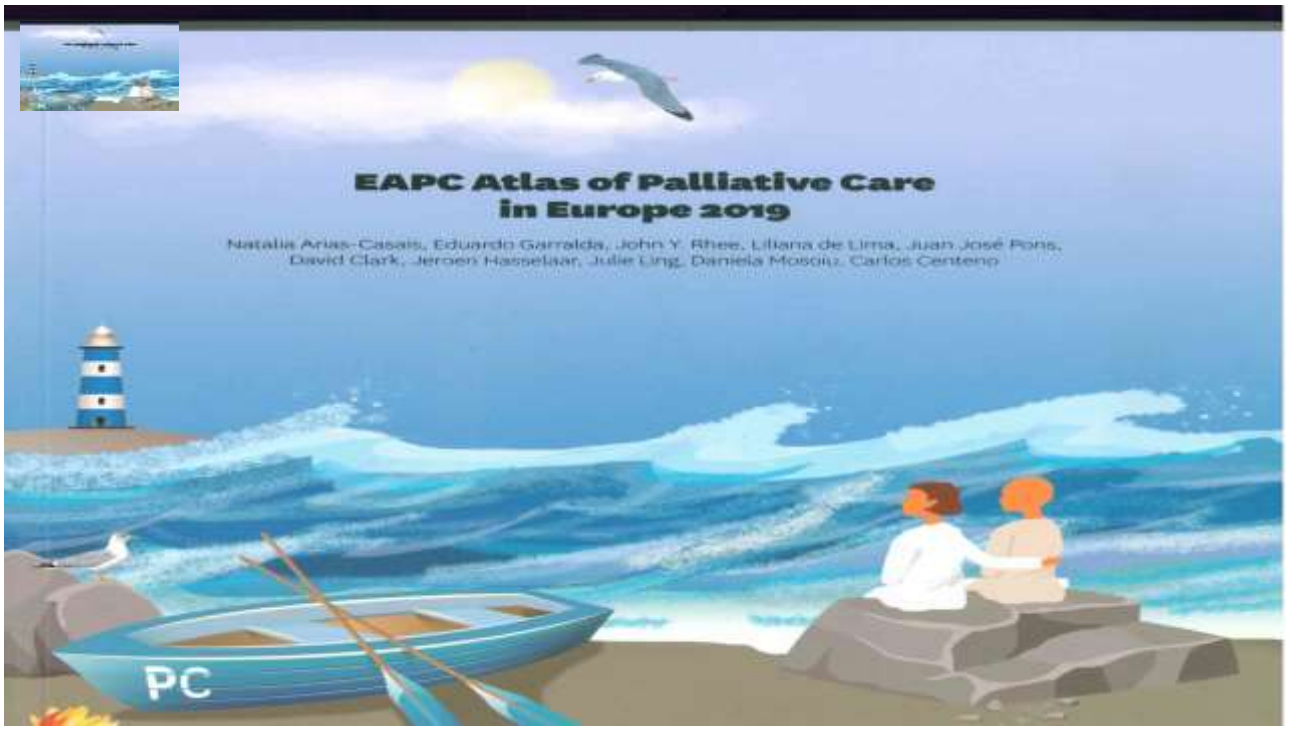
The abyss is broad and deep, mirroring relative and absolute health and social deprivation.

Of the 298·5 metric tonnes of morphine-equivalent opioids distributed in the world per year (average distribution in 2010–13), only 0·1 metric tonne is distributed to low-income countries.1 The amount of morphine-equivalent opioids distributed in Haiti is 5 mg per patient in need of palliative care per year, which means that more than 99% of need goes unmet. By contrast, the annual distribution of morphineis 55 000 mg per patient in need of palliative care in the USA and more than 68 000 mg per patient in need of palliative care in Canada—much more than is needed to meet all palliative care and other medical needs for opioids on the basis of estimates of the Commission (figure 1).

The fact that access to such an inexpensive, essential, and effective intervention is denied to most patients in low-income and middle-income countries (LMICs) and in particular to poor people—including many poor or otherwise vulnerable people in high-income countries—is a medical, public health, and moral failing and a travesty of justice.

Unlike so many other priorities in global health, affordability is not the greatest barrier to access, and equity-enhancing, efficiency-oriented, cost-saving interventions exist.

Knaul FM, et al; **Lancet Commission on Palliative Care and Pain Relief Study Group**. Alleviating the access abyss in palliative care and pain relief-an imperative of universal health coverage: **the Lancet Commission report. Lancet. 2018 Apr 7;391(10128):1391-1454**. doi: 10.1016/S0140-6736(17)32513-8. Epub 2017 Oct 12. Erratum in: Lancet. 2018 Mar 9;: PMID: 29032993



Some barriers hindering access to pain relief account for problems related to availability , affordability and prescription limitations among others

MORPHINE AVAILABILITY IN THE PUBLIC Health Sector

- ✓ **In Europe 38/51 Countries estimate availability of immediate release oral morphine** (in liquid or tablet) in over 50% of pharmacies of primary care level **(2019 before Brexit)**
- ✓ Availability remains an issue in a number of countries mostly in Central and Eastern Europe
- ✓ Some countries report availability limitations restricted to specially-licensed pharmacies (i.e.Armenia), general Hospital (i.e. Cyprus) or to certain type of formulation (i.e. Bulgaria)

OPIOID PRESCRIPTION REQUIREMENT

- ✓ 41/51 countries reported having special opioids prescription form
- ✓ **7/51 countries not report a special opioid form (Denmark, Finland, Iceland, Ireland, Nethderlands, Portugal, Switzerland and the United Kingdom- in *Italy too since 2010*)**
- ✓ 14/51 countries reported no time limits prescriptions
- ✓ 4/51 countries reported prescriptions to be limited over a month
- ✓ 21/51 countries count with prescriptions limited to few weecks (less than a month)
- ✓ 9/51 countries reported prescription limited to few days
- ✓ 45/51 countries do not require patients to register as opioid users to qualify for an opioid prescription
- ✓ 6/51 countries require patients to register as opioid users to qualify for an opioid prescription

EAPC Atlas of Palliative Care in Europe 2019

PROFESSIONALS ALLOWED TO PRESCRIBE OPIOIDS

In 42/51 countries opioids can be prescribed by all General Practitioners and Family Doctors

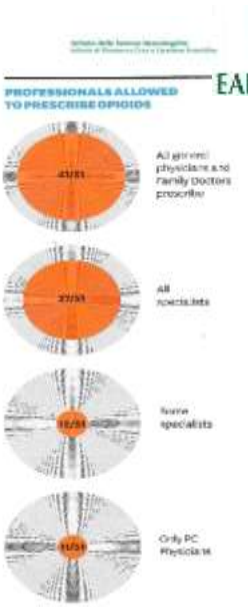
In 5/51 countries General Physicians and Family Doctors are not allowed to prescribe them (Bosnia and Herzegovina, Kyrgyzstan, Macedonia, Slovakia and Tajikistan)

In 37/51 countries opioid prescription is allowed to all specialists

In 12/51 countries opioid prescription is allowed to some specialists (i.e. Oncologist, Internists, Surgeons)

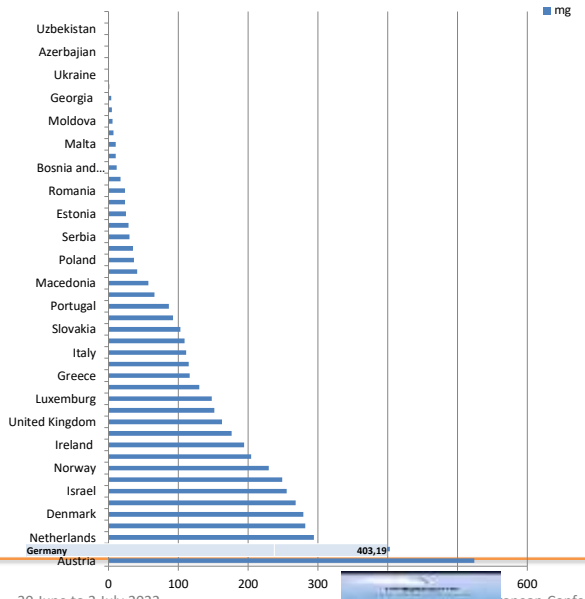
11/51 countries report that only PC-trained physicians can prescribe opioids

In 2/51 countries have registered non-medical prescribers PC- trained nurse can prescribe opioids (United Kingdom and Ireland)



EAPC Atlas of Palliative Care in Europe 2019

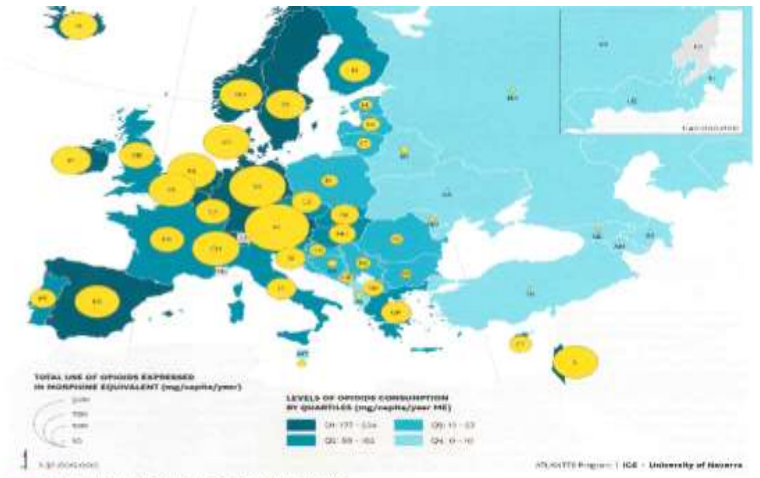
CONSUPTION OF STRONG OPIOID ANALGESICS PER CAPITA/YEAR



Country	mg
Austria	524,01
Germany	403,19
Netherlands	294,21
Switzerland	281,85
Denmark	279,34
Belgium	268,28
Israel	255,35
Spain	249,09
Norway	229,62
Sweden	204,42
Ireland	194,51
Iceland	176,5
United Kingdom	162,44
France	151,83
Luxemburg	148,16
Finland	129,92
Greece	116,4
Slovenia	114,73
Italy	111,4
Czech Republic	109,08
Slovakia	103,09
Hungary	92,58
Portugal	86,52
Cyprus	66,06
Macedonia	57,18
Latvia	40,89
Poland	36,57
Croatia	35,15
Serbia	29,91
Lithuania	28,56
Estonia	25,08
Montenegro	23,48
Romania	23,45
Bulgaria	17,45
Bosnia and Herzegovina	11,9
Belarus	10,37
Malta	10,2
Albania	7,31
Moldova	5,75
Russian federation	4,65
Georgia	4,07
Turkey	1,28
Ukraine	0,78
Kazakhstan	0,77
Azerbajian	0,39
Armenia	0,27
Uzbekistan	0,22
Tajikistan	0,0

EAPC Atlas of Palliative Care in Europe 2019

CONSUPTION OF STRONG OPIOID ANALGESICS PER CAPITA



Map 3.1. Consumption of Strong Opioids across Europe in 2017.

EAPC Atlas of Palliative Care in Europe 2019

The Lancet Commissions

EAPC

Alleviating the access abyss in palliative care and pain relief—an imperative of universal health coverage: the *Lancet* Commission report

Panel 2: An Essential Package Of Palliative Care And Pain Relief Health Services

The Essential Package contains the inputs for safe and effective provision of essential palliative care and pain relief interventions to alleviate physical and psychological symptoms, including the medicines and equipment that can be safely prescribed or administered in a primary care setting. The list of essential medicines in the Essential Package is based on WHO's list of essential medicines,[35] and considers the medicines, doses, and administration routes for palliative care for both adults and children.

The Essential Package is designed to be lowest cost by including only off-patent formulations, frugal innovation for needed equipment, and a staffing model based on competencies rather than professions. Tasks often undertaken by specialised medical personnel in high-income countries can be performed by other specialised and general practitioners and nurses or by community health workers empowered with the necessary training and medical supervision to participate effectively in the delivery of palliative care and pain treatment at all levels of care, from the hospital to the home.[10,12]

With the key exception of morphine, the medicines in the Essential Package are available in most countries even if supply is limited. For morphine, an essential palliative care medicine, assuring safety and accessibility is complex. Ensuring a balance between appropriate medical access to controlled medicines and the prevention of their diversion and non-medical use is crucial, and the Commission not only designed appropriate human resource models but also the strategies to provide the complementary policy and stewardship to expand access to an Essential Package that includes morphine.[12]

The health services of the Essential Package must be complemented by interventions for the relief of social and spiritual suffering to preserve the dignity of patients, facilitate access to health interventions, and prevent financial hardship and impoverishment. Yet, these social supports are neither part of the remit of health ministries nor should they be financed from a health budget.

Antipoverty and social development policies, publicly funded safety nets, programmes, and ministries must give special attention to ensure that families do not sacrifice their basic needs in desperate attempts to care for loved ones. These persons with life-limiting or life-threatening health conditions and their families should be mainstreamed into existing social support and social welfare programmes, yet they are often ignored, excluded, or marginalised, preventing

Medicines
- Amitriptyline
- Bisacodyl (Senna)
- Dexamethasone
- Diazepam
- Diphenhydramine (chlorpheniramine, cyclizine, or dimenhydrinate)
- Fluconazole
- Fluoxetine or other selective serotonin-reuptake inhibitors (sertraline and citalopram)
- Furosemide
- Hyoscine butylbromide
- Haloperidol
- Ibuprofen (naproxen, diclofenac, or meloxicam)
- Lactulose (sorbitol or polyethylene glycol)
- Loperamide
- Metoclopramide
- Metronidazole
- Morphine (oral immediate-release and injectable)
- Naloxone parenteral
- Omeprazole
- Ondansetron
- Paracetamol
- Petroleum jelly

Medical equipment
- Pressure-reducing mattress
- Nasogastric drainage or feeding tube
- Urinary catheters
- Opioid lock box
- Flashlight with rechargeable battery (if no access to electricity)
- Adult diapers (or cotton and plastic, if in extreme poverty)
- Oxygen

Human resources (varies by referral, provincial or district hospital, community health center, or home
- Doctors (specialty and general, depending on level of care)
- Nurses (specialty and general)
- Social workers and counsellors
- Psychiatrist, psychologist, or counsellor (depending on level of care)
- Physical therapist
- Pharmacist
- Community health workers
- Clinical support staff (diagnostic imaging, laboratory technician, nutritionist)
- Non-clinical support staff (administration, cleaning)

Knaul FM, et al; **Lancet Commission on Palliative Care and Pain Relief Study Group**. Alleviating the access abyss in palliative care and pain relief-an imperative of universal health coverage: **the Lancet Commission report. Lancet. 2018 Apr 7;391(10128):1391-1454**. doi: 10.1016/S0140-6736(17)32513-8. Epub 2017 Oct 12. Erratum in: Lancet. 2018 Mar 9;: PMID: 29032993

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EAPC Blog
The Blog of the European Association for Palliative Care

European Association for Palliative Care
One voice, one vision for palliative care

From the front line: Palliative care in Bologna during the COVID-19 crisis

Posted on March 22, 2020 by palleare

Dr Danila Valenti is Medical Director of UO Rete delle Cure Palli... palliative care unit in Bologna, northern Italy, and a member of th... Association for Palliative Care (EAPC) Board of Directors. Here, ... of the main challenges facing us in health care during the coronav... shares advice for others who are approaching a similar situation in their country.

2. **24-hour availability via a single telephone number for colleagues from the dozens of COVID departments** (distributed across nine hospitals, one university hospital and one research institute, for a population of about one million inhabitants – Local Health Authority) for a, b, c above.

(c) **Produce a Palliative Care Drug Kit to leave in the home.** This will enable management of all eventualities and should be supported by telephone. A 24-hour-a-day single phone number for palliative care advice for all patients, healthcare residences and long-term care providers should be available.

- one Palliative Care Network with an Operations Centre
- one Home Palliative Care Specialist service (30 doctors), (ANT Foundation)
- three Hospices (10 doctors) (Hospice Seràgnoli Foundation)
- 14 Early Palliative Care Clinics (outpatient service, ambulatory patients – consulting home care – consulting in nursing homes) nine doctors, 30 nurses

And:

- 600 general practitioners
- 52 nursing homes.

The Italian experience

Following the COVID-19 outbreak in Italy, the main advice to others who are approaching a similar situation is: **Rearrange, rearrange, rearrange**. Palliative care services in this emergency must be flexible and adapt and change their organisation as needed to guarantee care to those who need it most.

The experience in Italy indicates that one of the main problems during this crisis has been the lack of availability of Personal Protective Equipment (PPE). This has proved to be the most important and limiting factor, not only in palliative care provision but for the whole healthcare system. In

Due to the risk of harm to patients, home palliative care visits **must be limited to those who actually need care.** There are two options:

1. **Discuss and share with colleagues the cases of families at home in order to make better decisions about care and to share the weight of these decisions.**
2. **Go to the patient's home with appropriate PPE**

(a) **Discuss and share the cases of patients who are discharged from hospitals** (new patients).
(b) **Share simple palliative care symptom management with colleagues** (analgesics and other

(a) treatments for pain and symptom management in particular (dyspnoea and palliative sedation);
(b) advice on how to talk to families **to avoid the 'Desaparecidos' effect**;
(c) ethical decision support;
(d) communication support with patients and family.

Local Health Authority of BOLOGNA (Italy)

L'Azienda USL di Bologna, con più di 8.000 dipendenti è responsabile della salute di 886.098 residenti, il 44% dei quali risiede nel comune di Bologna.

The Local Health Authority of Bologna serves a population of about one million inhabitants with:

- **9 hospitals**
- **1 University hospital**
- **1 research institute**.
- **52 Residential Aged Care Facility (RACF)**

In total there are approximately 3,000 acute beds and **3,000 beds in RACF**

PALLIATIVE CARE NETWORK

- **1 Palliative Care Network with an Operations Centre**
- **1 Home Palliative Care Specialist service (30 doctors), (ANT Foundation)**
- **3 Hospices (10 doctors) (Hospice Seràgnoli Foundation) with 58 beds**
- **14 Early Palliative Care Clinics (outpatient service, ambulatory patients – consulting home care – consulting in nursing homes) nine doctors, 30 nurses**.

10° March 2020

PALLIATIVE CARE NETWORK DURING COVID OUTBREAK March 2020

Fabrizio Moggia and Danila Valenti

And Alice Trentini , Federico Fabbri, Claudia Morganti, Maria Rocchi, Lucrezia Vita Finzi, e Luigi Gatta
Volunteer Medicine Students of the project "a un metro da te..."

SERVIZIO SANITARIO REGIONALE
EMILIA-ROMAGNA
Azienda Unità Sanitaria Locale di Bologna

Istituto delle Scienze Neurologiche
Istituto di Ricovero e Cura a Carattere Scientifico

Dipartimento dell'Integrazione
Cure delle Cure Palliative
Direttore : dott.ssa Danila Valenti
DATeR: Processo assistenziale nelle Cure Palliative
Responsabile: dott. Fabrizio Moggia

HOME PC PATIENT KIT
O.U. Palliative care network

Drugs	Minimum stock
Dexamethasone 4 mg/ml fl	3 pkts
Metilprednisolone, 16 mg, Butilscopolamine	1 pkt
	1 pkt
	1 pkt
Acetaminophen 1000 mg cp	1 pkt
Ketorolac 30 mg/ml fl	1 pkt
Furosemide 20 mg/2 ml fl	1 pkt
Metoclopramide cp, vials	1 pkt
	1 pkt
	1 pkt
Loperamide Macrogol Laxative	1 pkt
	1 pkt
	1 pkt
	1 pkt

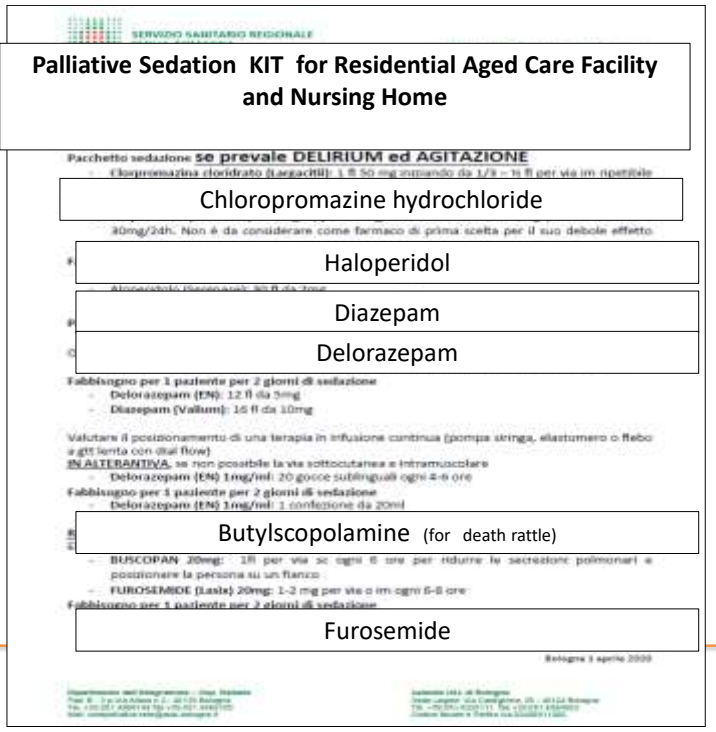
Drugs	Minimum stock
Chlorhexidine	1 pkt
Amukine med	1 pkt
Sterile gauzes	3 pkt
Paper plaster	1 unit
Rectal probe	1 unit
Fosfolax clyster	1 unit
Micro-enema	1 pkt
Urologic luan	1 unit
Cone-catheter syringe	2 units
Physiological solution 10 ml	5 flac.
Physiological solution 100 ml	1 flac.
Physiological solution 500 ml	1 flac.
Syringe 1 ml	10 units
Syringe 5 ml	5 units
Syringe 10 ml	5 units
Surgical mask	2 units
Halibox	1 unit

Leave the prescription of opioids during the take in charge examination
Morphine sulfate immediate release
H 10MG VIALS

ASK THE FAMILY TO BUY:
Liquid soap
Kitchen paper for the workers
Disposable gloves

Translated by Gatta Luigi, Fabbri Federico

Palliative Sedation KIT for Residential Aged Care Facility and Nursing Home



Dr. Morena BORSARI
Director of the Pharmaceutical Department , Local Health Authority of Bologna, IRCCS e Hospital University S.Orsola, Bologna

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EAPC

PALLIATIVE CARE NETWORK
COVID EMERGENCY

OPERATIONS CENTRE /H24
Tel 0516225652 – Fax: 0514966150
curepalliative.rete@ausl.bologna.it

COUNSELING MANAGEMENT
PALLIATIVE CARE
H24
FOR COVID-19 UNIT

SKYPE: Danila Valenti

Valenti
Mengoli
Taberna
Di Mirto
Other doctor
in project:
Student
(graduated in medicine | 1 night shift)

Psychologist: Baron

LOCAL EQUIPES (8 A.M. – 8 P.M. – Doctor 9 A.M. – 1 P.M.):

COVID-19:
NON-COVID-19, SUSPECT COVID-19 AND LOCAL COVID-19 :

Ospedale Maggiore
Ospedale Bellaria
Navile
S.Orsola Pad. 5 a Rima
S.Lazzaro
Ospedale Bentivoglio
Ospedale S.Giovanni
Ospedale Vergato

ECOP 5

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For Hospital Wards

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PRACTICAL INSTRUCTIONS FOR USING MORPHINE AND MIDAZOLAM IN PATIENTS WITH COVID19 PNEUMONIA

Written in accord with Dr. ZACCARONI for wards 08-62 and 63

DYSPNOEA:

If possible evaluate dyspnoea as a subjective symptom, asking the patient to describe it on an NRS scale from 0 (no breathing fatigue) to 10 (intolerable air hunger)

If the patient has NOT taken opioids:

- CHLORHYDRATED MORPHINE 10mg vials: administer 2,5mg boluses (1/4 of the vial) SC, undiluted, in insulin syringe. Repeat every 4-6h.
- Increase by 50% the dosage of boluses if ineffective.

If useful, once found the effective daily dosage (typically 15-30 mg/24h):

1. Bolus: chlorhydrated morphine 2,5-5mg subcutaneously each 4-6h; or
2. IV drip: 250ml → infuse the daily dosage in physiologic solution in slow continuous infusion on 24h (slow drop on dial flow), or subcutaneously; or
3. Continuous infusion (syringe pump): chlorhydrated morphine 15-30mg diluted in physiologic solution and infused EV on 24h (if preferred, use an elastomeric pump).

→RESCUE THERAPY: chlorhydrated morphine 2,5-5mg (bolus) EV or SC (1/6 of total daily dose)

Should the IV drip terminate in less than 24h, prepare a new on and restart the infusion (you should avoid leaving the patient out of morphin)

It is possible to blend morphine and midazolam!

SEDATION OF REFRACTORY SYMPTOMS and/or agonic phase

Use Midazolam to obtain palliative sedation (morphine alone does NOT guarantee deep sedation)

- Induction: Midazolam 2,5 mg (half 5mg/ml vial) subcutaneous bolus (reach 10cc with physiologic solution in syringe), possibly repeatable after 10 min. in necessary.
- Implement a continuous infusion therapy at an initial daily dosage of about 1 mg/h → 30 mg/24h:
  - IV drip: 250 ml or 500ml of physiologic solution in 24h; infuse the midazolam daily dose (30 mg) EV or (if no venous access is available) SC (slow drop on dial flow) in 24h; or
  - Continous infusion (syringe pump): infuse the midazolam daily dose (30 mg) EV or (if no venous access is available) SC in 24h (if preferred, use an elastomeric pump)
- NB: continuous infusion of MIDAZOLAM may be substituted by DIAZEPAM 10mg ( ) (2 or even 3 vials in 24h).

RESCUE THERAPY: MIDAZOLAM 2,5-5 mg (bolus) ev or sc (increase if the daily dose has increased)

TERMINAL RATTLE

Use Butilscopolamine 1fl SC each 6 hours to lower pulmonary secretions (anticholinergic effect).

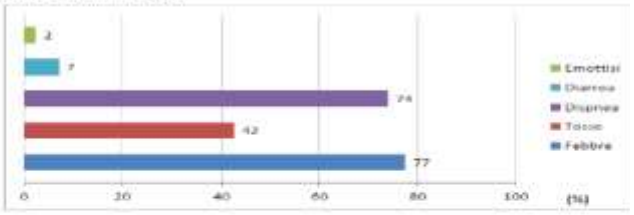
For any question:
Palliative Care Network 051 6225652
24/7

Tradotto da Vita Finzi Lucrezia, Gatta Luigi

ECOP 5

For Residential Aged Care Facility and Nursing Home

Most frequently encountered symptoms in diseased COVID-19+ (Superior Institute of Health report – 17th of March 2020)



MAIN SYMPTOMS

Patients affected by COVID-19+ pneumonia may present:

1. Fever
2. Dyspnoea
3. Cough
4. Diarrhea
5. Hemoptysis
6. Delirium/mania/psychomotor agitation (pre-agonic phase)
7. Terminal rattle (agonic phase)

Point 6 and 7 may require deep palliative sedation

FEVER

THERAPY: specific if indicated

PARACETAMOL 500mg every 6-8h

DYSPNEA

THERAPY:

- **CLORHYDRATED MORPHIN** 10mg vials: administer 2,5mg boluses (1/4 of the vial) SC, undiluted, in insulin syringe. Repeat every 4-6h. Increse by 50% the dosage of boluses if ineffective.
- Continuous infusion therapy: once found the effective daily dosage, at least 10-15mg every 24h diluted secondly to the method of infusion (e.g. Syringe pump, elastomer or slow throw IV with dial flow)

- If the patient is ALREADY in OPIOID THERAPY:
  Increase the total daily dosage by 25-50% and associate
  - **DEXAMETHASONE** 1 4mg vial SC

  And in presence of **vomit:**
  - **METOCLOPRAMIDE** 1 10mg vial SC or IM every 8-8h

COUGH

CODEINE 20 drops 4 times a day

Consider that **morphine** reduces cough (DO NOT administer codeine if the patient is already in morphine therapy)

DIARRHEA (infrequent but possible)

LOPERAMIDE 1 tablet after each diarrheal download

Consider that **morphine** reduces diarrhea (DO NOT administer loperamide if the patient is already in morphine therapy)

HEMOPTYSIS

TRANEXAMIC ACID: 1-2 500mg vials OS o IM twice a day (after clinical evaluation)

For Residential Aged Care Facility and Nursing Home

PALLIATIVE SADATION IN NURSING HOME

Palliative sedation *means*: intentional reduction of alertness with pharmaceuticals, until the loss of consciousness, with the aim to reduce or abolish the perception of a refractory symptom, otherwise intolerable for the patient

Refractory symptom *means*: uncontrolled symptom despite having tried any possible treatment which lefts the state of consciousness uncompromised. This also applies in the case there are no other palliative treatments available in time and/or cost-benefit balance tolerable for the patient. Most frequently it is delirium, dyspnoea, psychomotor agitation, convulsions. In minor percentage pain and vomit.

THERAPY

- if **DELIRIUM** and **AGITATION** prevail:
  - **Chlorpromazine hydrochloride**: 1 vial of 50 mg starting with 1/3 – ½ vial IM repeatable every 4 - 12h

Or

- **Haloperidol** vial of 2mg or 5mg/2ml. Start with 1 vial of 2mg SC up until to 30mg/24h. It is not to be considered as a first-choice drug due to its weak sedative effect, in fact it is often prescribed in association with a benzodiazepine
- if **DYSPNOEA** and **AIR HUNGER** prevail:
  - **Delorazepam 5mg**: 1-2 vials SC or IM every 8-12h

Or

- **Diazepam 10 mg**: 1-2 vials SC or IM every 6-8h

Evaluate continuous infusion therapy (syringe pump, elastomer or slow throw IV with dial flow)

ALTERNATIVELY, if SC or IM are not possible

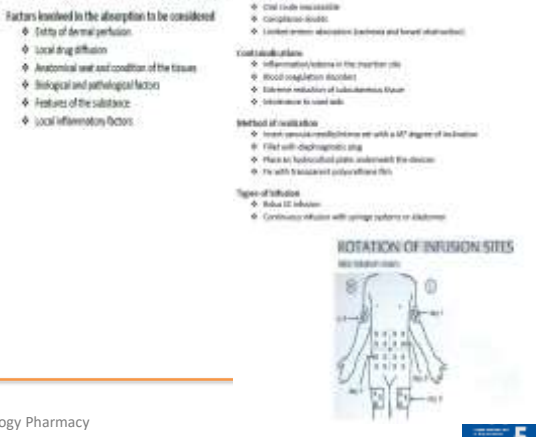
- **Delorazepam 1mg/ml**: 20 sublingual drops every 4-6h

TERMINAL RATTLE

Eliminate liquids in therapy, if present

- **BUTYLSCOPOLAMINE 20mg**: 1 vial SC every 6h to reduce pulmonary secretions. Place the patient on his side
- **FUROSEMIDE 20mg**: 1-2 mg SC or IM every 6-8h

ASSISTANCE ASPECTS in life-end care



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For Residential Aged Care Facility and Nursing Home

PRACTICAL INSTRUCTIONS FOR USING MORPHINE IN PATIENTS WITH COVID19 PNEUMONIA

Addressed to Nursing and retirement home

DYSPNOEA:

If possible evaluate dyspnoea as a subjective symptom, asking the patient to describe it on an NRS scale from 0 (no breathing fatigue) to 10 (intolerable air hunger)

If the patient has NOT taken opioids (naive patient):

- CHLORHYDRATED MORPHINE 2.5 mg (1/4 of 10 mg vials) SC, undiluted. Repeat every 4-6h (Leave the cannula in place to administer the therapy).
- increase by 50% the dosage of the boluses if the therapy is inefficient.
- METOCLOPRAMIDE 1 vial/IM x 2/die for 5 days

If useful, once found the effective daily dosage (typically 20-30 mg/24h): Place continuous infusion therapy:

1. Bolus of 250 ml: infuse the daily dosage of morphine in physiological solution in slow continuous infusion on 24h (slow drop on dial flow), or subcutaneously; or
2. Syringe pump (not necessary) : chlorhydrated morphine 15- 30mg diluted in physiologic solution and infused EV on 24h (if preferred, use an elastomeric pump)

RESCUE THERAPY: chlorhydrated morphine 2.5-5mg (bolus) EV or SC (1/6 of total daily dose)

- Should the IV drip terminate in less than 24h, prepare a new on and restart the infusion (you should avoid leaving the patient out of morphine)

ALTERNATIVELY, IF parenteral therapies are impossibile, use [Morphine sulfate immediate release] phialoid: half phialoid sublingual or diluted in water/gel water, EVERY 4 H (6h in case of Chronic Kidney Disease)

SEDATION OF REFRACTORY SYMPTOMS and/or agonic phase

Use sedatives to achieve the palliative sedation (morphine alone DOES NOT guarantee deep sedation)

For the sedation evaluate a continuous infusion therapy (chlorhydrated morphine drip 250 ml SC in continuous infusion in 24h, slow drop on dial flow, or but not necessary, syringe pump or elastomeric pump).

- if DYSPNOEA and AIR HUNGER prevail:
  -Delorazepam 5 mg 1-2 vials SC or IM every 8-12 h
  OR
  - Diazepam 10 mg 1-2 vials SC or IM every 6-8 h
- if DELIRIUM and AGITATION prevail:
  - Chlorpromazine hydrochloride 1 vial 50 mg starting with 1/3 – ½ vial repeatable every 4 - 12h
  OR
  - Haloperidol vial 2 mg oppure 5mg/2ml. Start with 1 vial of 2mg SC 5-30mg/24h. It is not to be considered as a first-choice drug due to its weak sedative effect, in fact it is often prescribed in association with a benzodiazepine

EXCELLENT ALTERNATIVE TO SC OR IM FOR NURSING AND RETIREMENT HOMES:

DELORAZEPAM 1 mg/ml: 20 sublingual drops every 4-6 h

terminal RATTLE

Use Butylscopolamine 1vial SC every 6 h to reduce lung secretions (anticholinergic effect)

For any doubt:

Palliative Care Network 0516225652

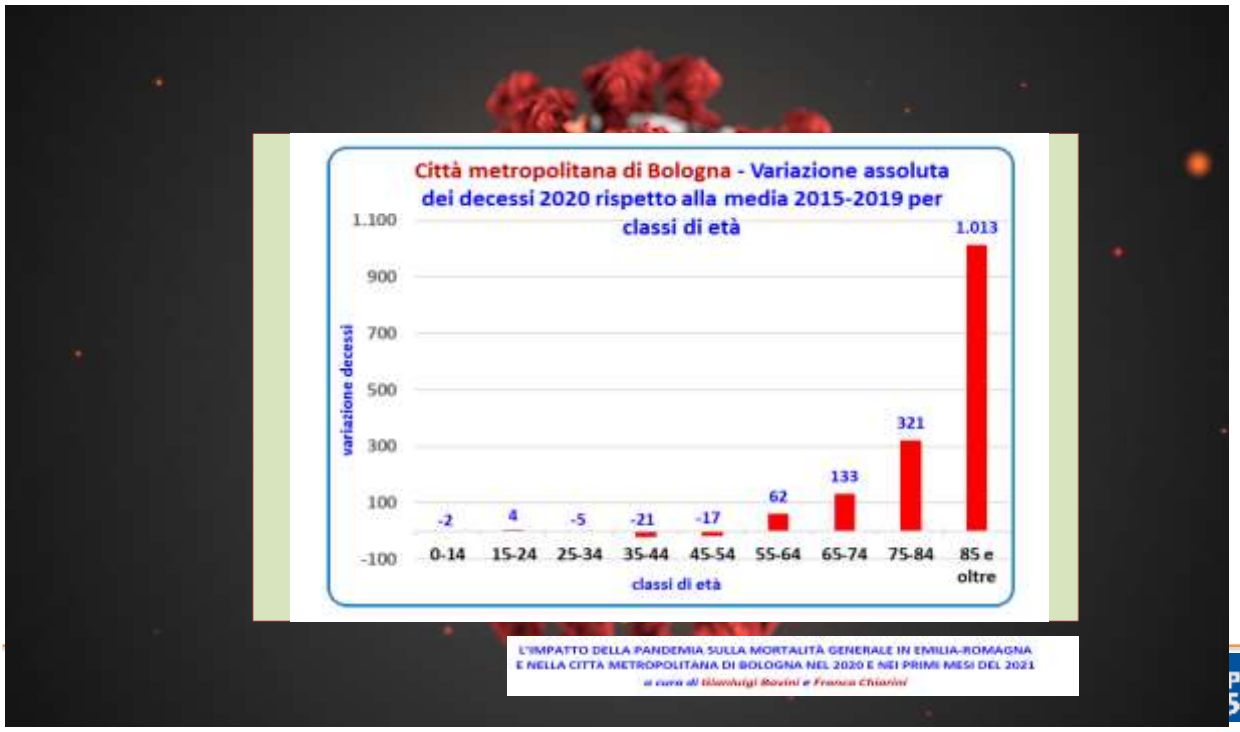
Centrale Operativa Rete delle Cure Palliative
Dipartimento dell'Integrazione – Osp. Bellaria

24h/24

SECOND WAVE of COVID -19 EMERGENCE

The curious case of Clergy House

The role of early palliative care palliative e simultanee



The curious case of Clergy House

22 dicembre: febbre – 1° Caso di positività al SARS COV-2

This slides describes a COVID-19 outbreak among elderly and frail residents of a nursing home, managed following the principles of palliative care.

Therefore, hospitalization was avoided and a novel paradigm of multidisciplinary management, tailored on the characteristics of the facility and residents, was implemented, with the primary goal to achieve physical and psychological comfort.

Patients' quality of life and priorities have been preserved and their outcome has been very good, with a lower than expected mortality.

Un paziente in fase terminale di malattia oncologica

The curious case of Clergy House

22 dicembre: febbre – 1° Caso di positività al SARS COV-2

29 Clergyman

OXIGEN THERAPY :

6 Pz (avarege of 3,1 L/minute - range 2-4)

ANTIBIOTICOTERAPY :

5 Pz

For 3 pazientes started in 6°, 5° e 3° day from the beginning of fever COVID antibiotici e 3 antibiotici)

For 2 pz for pathology NON COVID

CORTISTEROIDS

4 Pz

For 2 pz for COVID Simptoms (starting in 9° e 4° day)

For 2 pz for pathology NON COVID

IDRATATION :

1 Pz , 500 + 500 cc per ev

IDRATAZIONE ARTIFICIALE :

1 Pz , 500 + 500 cc per via endovenosa

Un paziente in fase terminale di malattia oncologica

Equipe Multidisciplinare e Multiprofessionale che ha agito nell'ambito di una Comunità di Pratica dal 22 dicembre 2020 al 18 gennaio 2021 presso una casa di riposo (casa del clero)

Professionista in presenza (Pres) (Rosso)

Professionista contattato al telefono (T) dal professionista in presenza (Azzurro)

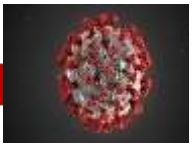
DATA Professionista	22 Dic 2020	23 dic	24 dic	25 dic	26 dic	27 dic	28 dic	29 dic	30 dic	31 dic	1 Gen 2021	2 gen	3 gen	4 gen	5 gen	6 gen	7 gen	8 gen	9 gen	10 gen	11 gen	12 gen	13 gen	14 gen	15 gen	16 gen	17 gen	18 gen
Infermiere Casa del Clero h24e Direttore della Struttura																												
MMG		T	T			T	T	T	T	T				T	T		T	T			T	T	T	T	T			
USCA						T				T		T		T			T	T		T	T							
Medico spec. in Cure Palliative		T																			T		T		T		T	T
Infermiere Cure Palliative		T		T						T	T	T						T						T				
Infermiere SID										T				T	T													
Infettivologo							T		T			T						T			T			T	T			
Geriatra																												
Cardiologo								T								T												
Pneumologo									T					T														
TASK Force Distrettuale (																												
Professionisti Dip Sanità Pubblica		T	T	T			T			T								T			T	T		T	T	T	T	
Professionisti DCP			T				T			T							T											
Fisioterapista volontaria																												
Medico Dipartimento Emergenza			T							T											T							

Rapid

La Biblioteca

The curious case of Clergy House

22 dicembre: febbre – 1° Caso di positività al SARS COV-2



29 Clergyman

The management of the outbreak was based on: i) involvement of a multi-professional and multidisciplinary healthcare team led by a palliative care physician; ii) avoidance of hospital admission; iii) prevention of social isolation.

Results: The outbreak lasted from 23 December 2020 to 18 January 2021**.** **Twenty-five out of 29 residents had a nasopharyngeal swab positive for SARS-CoV-2; they had a median age of 88 years** , a median Charlson index of 9 and a median frailty index of 4

Sixteen residents had a symptomatic infection, 6 needed oxygen supplementation. Only one patient died but his death was due to a pre-existing end-stage neoplasm.

Conclusions: the outcome of elderly patients with COVID-19 managed according to a person-centered paradigm of care has been better than expected and this kind of approach may represent a model for the management of acute illnesses in older people.

16 Sintomatics

OSSIGENO TERAPIA :
6 Pz (con una media di 3,1 litri al minuto - range 2-4) di cui 2 presenti pre-prescritta per patologie non covid relate.

ANTIBIOTICOTERAPIA :
5 Pz
per 3 pz iniziata in 6°, 5° e 3° giornata dalla comparsa di febbre da COVID (rispettivamente eseguiti 3 antibiotici, 2 antibiotici e 3 antibiotici)
per 2 pz la terapia antibiotica è stata eseguita per patologie non COVID relate

TERAPIA CORTISONICA :
4 Pz
in 2 pz per sintomatologia da COVID (la terapia è stata iniziata in 9° e 4° giornata dall'inizio dei sintomi)
in 2 pz per patologie NON COVID
ad una dose che, per personalizzazione della terapia, non ha mai superato i 16 mg di metilprednisolone per os.
IDRATAZIONE ARTIFICIALE :
1 Pz , 500 + 500 cc per via endovenosa

Un paziente in fase terminale di malattia oncologica


palliPHARM

FACTSHEET

Core Palliative Care Medicines for Queensland Community Patients

Introduction

Community-based palliative patients need timel... end-of-life (terminal phase) symptoms are opt... recommends community pharmacies and res... medicine from each of the five medicine categor...

Core Palliative Care Medicines List f...

Medicine Category	Medicines	
	First Line	Sec...
Analgesic (High potency opioid)	Morphine (sulfate or hydrochloride) 10mg/mL and/or 30mg/mL injection	Fent... 100... Hyd... 2mg
Anticholinergic	Hyoscine butylbromide 20mg/mL injection	
Antiemetic	Metoclopramide 10mg/2mL injection	Halo... Inje...
Antipsychotic	Haloperidol 5mg/mL injection	
Anxiolytic	Midazolam 5mg/mL injection	Clon... 1mg...

Refractory

This list does not restrict which medicines can be prescribed for individual palliative patients, but is one approach which will allow community pharmacies to anticipate medicines most likely to be prescribed, and allow prescribers to anticipate medicines most likely to be available for rapid supply in Queensland pharmacies and RACFs.

Funding
This statewide project has been funded by Queensland Health for one year until June 2021.

More information:
1300 90080
palliPharmHealth.qld.gov.au
psa.org.au/palliPharm

What is ?

Core palliative care medicines and indication/(s) for use in the last days of life

Community pharmacists should consider stocking medicines on the 'NSW Core Palliative CareMe dicines List for NSW Community Pharmacy,' and where clinically appropriate, prescribers should consider prescribing medicines from the core list for patients being cared for in their own home, or in a community setting such as a Residential Aged Care Facility.

Pharmacists are also encouraged to inform their local prescribers that their pharmacy has stock of each of the five core palliative care medicines.

The NSW government funded a survey of all community pharmacies in Australia (NSW) in 2018.

<u>The survey demonstrated a need to improve medicine access for patients who choose to spend their last days of life in the community.</u>

The survey findings indicate that if consistent prescribing of medicines on the core list is promoted, it is likely that medicines on the list will be supplied before they expire, mitigating the financial risk to pharmacies

...ology Pharmacy

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OPIOIDS CRISIS

Opioids are highly recommended by the World Health Organization (WHO),[1] particularly in cancer pain management,[2] due to their advantageous analgesic effect, multiple routes of administration, ease of titration, and lack of dose-ceilingn effect.

OPIOIDS CRISIS

In the early 1990s, the current opioid epidemic in the United States (US) was founded on a movement aimed to address the problem of undertreated chronic noncancer pain.

In 1997, the American Pain Society and the American Academy of Pain Medicine published a consensus statement recommending the use of opioids to treat chronic noncancer pain, **arguing that the risk of opioid addiction was minimal.**

Contemporarily, a broad array of pharmaceutical industries concerted efforts to promote opioids as a safe, nonaddictive, effective, and humane alternative to treat chronic noncancer pain.

These marketing efforts certainly accelerated the shift in the treatment paradigm **for chronic Pain**

Kurita G.P. Per Sjogren P.: Management of cancer pain: challenging the evidence of the recent guidelines for opioid use in palliative care, POLISH ARCHIVES OF INTERNAL MEDICINE 2021; 131 (11) Copenhagen University Hospital, Copenhagen, Denmark

It should be underpinned that the distorted patterns of the worldwide availability and accessibility of opioids are a sensitive and complex issue.

There are high-income countries in opioid crisis fighting against the iatrogenic opioid overuse and there is a global pain crisis involving many middle- and low-income countries with limited access to opioids.

A balanced approach including, among others, regulations on prescribing opioids and adequate training of health care professionals is recommended to improve the access to pain treatment with opioids.[13]

Kurita G.P. Per Sjogren P.: Management of cancer pain: challenging the evidence of the recent guidelines for opioid use in palliative care, POLISH ARCHIVES OF INTERNAL MEDICINE 2021; 131 (11) Copenhagen University Hospital, Copenhagen, Denmark

Take Home Message

Palliative Care is: 1) a core component of disease management,.m, and 2) integrated from point of diagnosis of a lifethreatening or life-limiting health condition.

Opioids, specifically morphine, remain the first-choice analgesic for moderate to severe cancer-related pain.

The Core Palliative Care Medicines List for Community Pharmacy for use in the last days of life has Clonazepam ,Haloperidol , Hyoscine butylbromide , Metoclopramide and Morphine

There are high-income countries in opioid crisis fighting against the iatrogenic opioid overuse and there is a global pain crisis involving many middle- and low-income countries with limited access to opioids.

A balanced approach including, among others, regulations on prescribing opioids and adequate training of health care professionals is recommended to improve the access to pain treatment with opioids.

The access to Opioids, so different in the world, is a medical, public health, and moral failing and a travesty of justice.