LMC End of Life Update 01 04 2020

Over the weekends, and especially over the Easter weekend, we might suggest that you judiciously provide your palliative patients with a number to contact you, in extremis. We recognise that this is not necessarily usual practise for all, but this is an extraordinary time. It may well be that a next of kin would feel much more comfortable seeking advice from a GP they know and trust to feel more comfortable to deliver a prescribed medicine for end of life, which could make all the difference to that family, facing death alone.

Some of you may have missed the post on The Link (contact office@cambslmc.org to register if you are a Cambs GP or practice manager) from Dr Stephen Barclay around buccal and sublingual meds in end of life care. The key points are repeated below:

- The buccal / sublingual route would be for those unable to swallow oral meds, as in 'normal' palliative care where we would switch to the subcutaneous route. It is likely that syringe drivers will be in very short supply and availability of a clinician to give 4-hourly prn s/c injections may be very limited, so the long half-life of levomepromazine (approx. 18 -24 hours) is particularly helpful. This is also easier for family to administer buccal / sublingual meds, though that needs training and support and careful selection of appropriate people and home circumstances. Family carers may need debriefing afterwards.

- Buccal morphine: this is best being injectable morphine rather than oramorph. If able to swallow and absorb from GI tract, continue using oramorph as usual.

- Buccal midazolam has quicker onset of action of circa 20 minutes compared with sublingual lorazepam of circa 60 minutes. Many people dying with or from COVID have a gradual decline over 24 hours or so that we are familiar with; but some have a rapid decline over hours with delirium due to hypoxia, breathlessness and severe distress for which buccal morphine and midazolam will give rapid relief. The buccal levomepromazine will maintain the sedation after the first two drugs are wearing off. Larger doses of these drugs than we are familiar with may be needed as indicated in the prescribing guidance on the LMC website.

- The 24/7 hospice telephone advice will be there to support and guide health and social care professionals and will be pleased to help. It is hoped that in these exceptional times family carers set up to administer these drugs will be able to access 111 option 4 that is normally reserved for healthcare professionals, but this has not yet been formally agreed. We would reiterate that you will perhaps wish to pass on your contact details in extremis over a weekend, and especially a bank holiday weekend.

- Oxygen can be helpful for breathless COVID patients of which there may well be many, though the logistics of getting this into the home will be challenging, and even more pertinent will be the supply. Oxygen is much less helpful in the less common acute dying phase when sedation is more appropriate.

- A significant number of end stage Covid patients will need to be assisted to be comfortable while they die at home. It is unlikely that O2 therapy will have a beneficial place in their care. Given the resources we have, end of life palliative care will need to concentrate on respiratory distress.

- In due course, the needs of the bereaved will need consideration. In the coming months there will be multiple reasons for death to be much more challenging to process, whether or not a COVID related death. If we have capacity a phone call from the practice is likely to be appreciated.

- Likewise you may need a debrief, and the LMC Pastoral Support Team is here for you.

Best wishes,

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