



# Palliative care during COVID-19 epidemic

## Paliativna oskrba v obdobju epidemije s covidom-19

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### Abstract

The article presents the recommendations for palliative care symptom management during COVID-19 epidemic in different settings. The basis for the recommendations are curricula of the Slovenian Palliative and Hospice Care Association and current recommendations for the management of patients with COVID-19 who need palliative care, provided by European and world scientific associations. The guidelines are a direct response to unpredictable pandemic and are supported by scientific data and professional experience. We will review the recommendations in terms of their usefulness and update them as necessary.

### Izvešček

V prispevku so predstavljena priporočila za obravnavo simptomov v paliativni oskrbi bolnikov v različnih okoljih v obdobju epidemije s covidom-19. Podlaga za priporočila so učna gradiva za paliativno oskrbo Slovenskega združenja za paliativno in hospic oskrbo ter priporočila za obravnavo bolnikov s covidom-19 v paliativni oskrbi več evropskih in svetovnih združenj. Priporočila so odziv na trenutno stanje z okužbami s SARS-CoV-2 in slonijo na strokovnih dokazih ter izkušnjah. Uporabnost priporočil bomo sproti preverjali in po potrebi posodabljali z naslednjo verzijo.

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## 1 Introduction

Palliative care is a comprehensive treatment of patients with life-threatening disease, which also provides support to their loved ones during the course of the disease and after their passing. Its core purpose is to care for a person as a whole, as a person with individual physical, psychological, social and spiritual needs. Palliative care

is characteristically dynamic, as it has to constantly adapt to the current needs of the patient and their loved ones, while through active planning, it also works effectively in preventing unnecessary complications. Palliative care must be provided where the patient needs it: at home, at a residential care home (RCH), and at

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healthcare establishments. It is provided by physicians and nurses in team collaboration with social workers, psychologists, physical therapists, dietitians, spiritual guides, volunteers, and other experts, when needed.

The increased rate of COVID-19 infections presents a great challenge for various aspects of palliative care. An optimal level of care for symptoms must be provided both to people who were previously healthy but are now infected with the SARS-CoV-2 virus, and to those who have already had a known advancing, incurable disease with a simultaneous infection with the SARS-CoV-2 virus, or without it.

During this period, healthcare workers expect several patients with so-called laboured breathing (dyspnoea), coughing, restlessness, psychological anxiety, as well as a bigger share of patients who will require good care at the end of their life, i.e., while dying.

The three basic recommendations of palliative care are:

*I. Palliative care must be provided wherever it is needed, in hospitals, residential care homes and at patients' own homes.*

*II. When we treat a patient with COVID-19 or a patient who is already in medical care, but has symptoms that are difficult to manage or more complex problems, healthcare providers should consult the physician with special knowledge of palliative care.*

*III. All hospitals should provide the option of consultation in the process of difficult ethical decisions at the location where the patient's care is being provided. We recommend that ethics committees or consultants faced with ethical dilemmas should also include experts in palliative care, and that they are included in all "key" decisions during the pandemic (at emergency rooms, isolation wards, intensive care therapy wards). Such support should be available to the staff as widely and early as possible.*

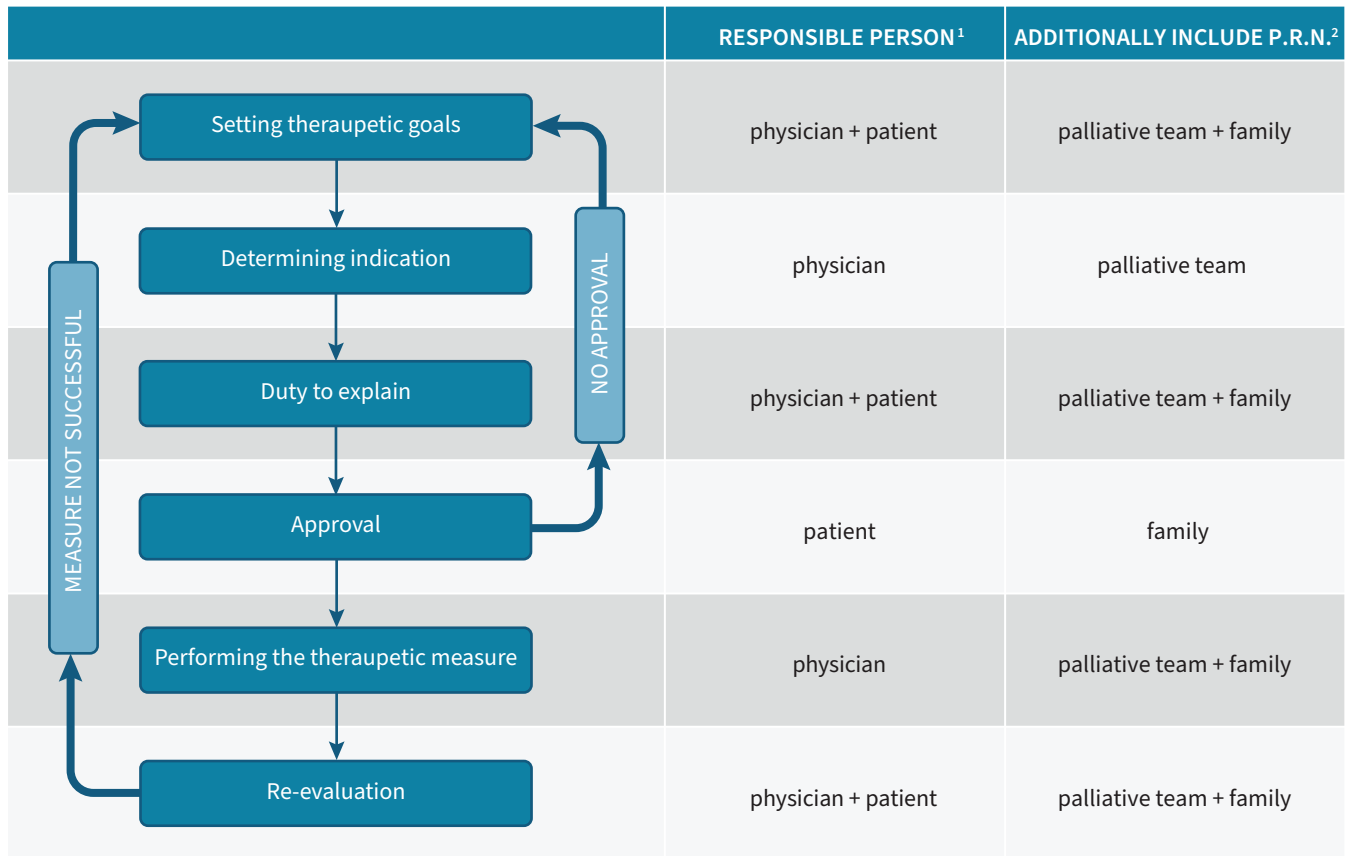
## 2 Basic considerations regarding the increases or limitations of care for patients with COVID-19

Patients who fall ill from the SARS-CoV-2 virus infection may have comorbidities or they may not. Regardless of any comorbidities, it is important that healthcare workers are constantly aware that the COVID-19 disease may develop into acute respiratory failure, and even conclude with death. Easing the difficult-to-manage symptoms as part of palliative care is therefore especially important.

A decision in the scope of the diagnostic and therapeutic treatments is taken by the physician in line with medical doctrine. In the event that the available therapeutic measures cannot achieve the therapeutic goals set out, they are not recommended; however, the patient is always provided with optimum palliative care. In practice, this means that the physician must know the patient well, especially their functional condition. They have to check for any potential comorbidities and any presence of advance health care directives (i.e., available and correctly filled out advance health care directive form or a plan of care with an emergency condition). The decision on limiting therapeutic measures must be written down and documented before starting intensive care treatment, and, where possible, with the patient's and their family's consensus (Figure 1) (1).

## 3 COVID-19 and elderly patients

Even though every person infected with the SARS-CoV-2 virus can be in a life-threatening situation, the elderly (often frail and with several comorbidities) are more likely to develop a severe type of the disease, and there is a higher probability that the infection ends with death.



**Figure 1:** Parties participating in taking key steps regarding therapeutic measures (1).

1 When there is reasonable doubt regarding the patient’s ability to understand explanations and provide a conscious approval, it is important to include the patient’s representative or authorised person who can consult them in this process and represent them.

2 When this is sensible from a medical perspective or at the patient’s request.

According to the experience from Italy, the median age of the deceased is 80 years (2). In Slovenia, during the first wave of infections, 82% of people who died of COVID-19 were over 75 years old (3). With older people, the very severe developments of the disease with an uncertain outcome and end-of-life situations require good palliative care for the elderly.

When deciding to refer older people with several comorbidities to a hospital, this requires especially careful deliberation, and, if possible, a consultation with the patient, their relatives or their representative. At this consultation, all the advantages and shortfalls of treatment in a hospital or in a residential care home must be explained in detail, and allow the

patient and their relatives to participate in the selection of the available options.

When making decisions regarding the need for intensive care measures, the decisions are made by appropriate specialists, based on expertly grounded facts. Open, befitting, and compassionate communication with the patient and their relatives is an important aspect of palliative care. An easy-to-understand explanation, repeated several times, provided step by step, will make it possible for the patient and their relatives to develop realistic expectations and express wishes that will assist in making therapy-related decisions (4). An explanation that does not only provide the difficult nature of the infection, the potential negative outcome, and the probability

of care at an intensive care unit, but also the possibilities offered by palliative care, allows the patient to form an autonomous decision and to plan their treatment. An individual decision should be reported to the patient's relatives and documented (advance health care directive, plan for an emergency medical condition). The document should be available to all of the patient's care providers. If the patient decides not to go to the hospital, the plan of palliative care at home or at the residential care home should be followed.

#### 4 Core principles of treating symptoms of a patient with COVID-19

Patients who were infected with the SARS-CoV-2 virus manifest very different symptoms, from mild to strong, that may be life threatening. It is characteristic of COVID-19 that the condition changes fast, and that is why it is important to regularly monitor the patient and observe the symptoms of the disease to prepare for their manifestation in time:

- pre-prescribed drugs for symptoms that can be forecast, along with clear instructions for dosages and selecting the method of ingestion, suitable to the environment where the patient is receiving care;
- provision of all planned drugs (at home, at the residential care home, in the hospital), including the equipment for their application;
- prepared plan for care in the event of additional exacerbation with regard to the patient's medical condition.

The symptoms of the disease can be mitigated using pharmacologic and non-pharmacologic means.

All pharmacologic means for mitigating the symptoms have to be suitable for the environment where the patient care is performed (Tables 1 and 2).

### 5 Treating the most frequent COVID-19 symptoms in palliative care

Treating symptoms must adhere to the recommendations for palliative care in Slovenia and elsewhere (1,4,5,6,7,8,9,10,11).

In palliative care, drugs whose authorisation of a medical product does not have approved indications or adapted methods of application (i.e., off-label use) are often advised, as they have proven to be effective, useful and safe in practice. Consequently, we recommend these drugs or their method of application also in this article (12,13,14,15).

#### 5.1 Increased body temperature

The following drugs are recommended for lowering increased body temperature:

- *Paracetamol*; tab, oral suspension, suppository, 500–1000 mg per 6–8 hours, o., rectal;
- *Metamizole*; tab., drops, 500–1000 mg per 6–8 hours, o.

**WARNING:** For both drugs, the total dosage must not exceed 4 g per day.

#### 5.2 Coughing

COVID-19 patients often develop a dry cough, or a productive cough, caused by a secondary bacterial infection.

The cough is mitigated with opium alkaloids and morphine:

- *Pholcodine*; capsule, oral suspension, 10-20 mg/8 hours, o.;
- *Codeine*, tab., 30-60 mg/6-8 hours, o.;
- *Morphine drops*, 5 mg after meal/4 hours + if p.r.n. 5 mg/hour, o.;
- *Morphine*; CIVI, starting dosage: 5–10 mg/24 hours + p.r.n. 5 mg/hour, s.c., intravenously.

### 5.3 Shortness of breath or dyspnoea (respiratory distress)

We use nonpharmacologic and pharmacologic methods of treatment.

Nonpharmacologic methods include adjusting the position of the body (forward posture, pillow for arm support, etc.), relaxation, cooling the face with a cold wet towel (but without handheld fans, as to avoid additionally spreading aerosols), adding oxygen to inhaled air or high flow oxygen therapy, when partial oxygen blood saturation falls below 92%.

With a COVID-19 patient, safe oxygen supply has to be ensured according to current recommendations on safe oxygen supply for COVID-19 patients.

If dyspnoea persists despite optimum treatment of the core disease and the use of nonpharmacologic means, we use opioids. We generally use morphine, which is first titrated to effect. The dosage of a slow release opioid is obtained by calculating all daily dosages of fast acting forms, and dividing it to the proscribed time intervals. Slow release opioids with a constant drug concentration are better at mitigating symptoms than fast acting opioids. The dosage of a fast acting opioid, which is prescribed "as needed", is 1/6 (15%) of the daily dosage.

The method of using opioids for easing respiratory distress differs by whether the patient has never before used opioids (a so-called opioid-naive patient), or whether they have used them before (so-called opioid-experienced patient).

**Table 1:** Recommendations for pharmacologic treatment of the most common symptoms at home, at a residential care home (RCH) and in a hospital.

Symptom	Measure	Notes
<b>Elevated body temperature</b>		
	<b>paracetamol</b> , pill, suppository, o. susp. 500–1000 mg/6-8 h	Additional practical cooling methods.
	<b>metamizole</b> , pill, drops 500–1000 mg/6-8 h	
<b>Dyspnoea (respiratory distress)</b>		
<i>Patients who had not used morphines before</i>	<b>morphine drops</b> , 5 mg (5 drops)/4 hours + if p.r.n. 5 mg/hour	Fresh air supply. Raising the upper body part in bed. Calm environment.  With a stable clinical picture, it is recommended that titration be followed by prescribing slow release opioids and rescue doses of fast acting opioid p.r.n At a RCH, taking into account previous daily dosage, we can subcutaneous infusion with controlled flow + rescue doses in the 1/6th of the daily dose.
	<b>morphine sulphate</b> , pill 5 mg/4 hours + p.r.n. 5 mg/h	
	<b>morphine</b> , bolus dose, s.c. 2,5–5 mg/4 h + p.r.n. 2,5 mg/30 min	
	If the symptom has not been sufficiently mitigated, the next day morphine dose is divided into adjusted regular doses per 4 hours + a rescue dose suited to the needs.	
<i>Patients who already use morphine preparations</i>	recommended dose + rescue dose p.r.n. (1/6th of the daily dose)/ho	
<i>Patients who cannot orally ingest medicines</i>	If o. and s.c. is not possible, buccal administration is possible (lower effectiveness!).	
<b>Acute respiratory distress</b>		
	Along with morphine: <b>lorazepam</b> , pill, 1 mg s.l. + p.r.n./h (maximum 6–8 mg/24 h) <b>midazolam</b> bolus dose, s.c. 2,5 mg + 2,5 mg p.r.l./30 min	Acute respiratory distress For severe respiratory distress continued sedation with midazolam + p.r.l. s.c. doses.

**The options for managing dyspnoea with opioid-naïve patients:**

- we begin by giving fast acting opioid forms of morphine, and regularly repeat this, e.g., fast acting morphine – *morphine drops*; 5 mg (5 drops)/4 hours + 5 mg p.r.n. /hour, or
- we begin with low dosages of slow release forms of morphine, e.g., slow release morphine; 5–10 mg/12 hours + fast acting morphine; 5 mg p.r.n./hour.

**The options for managing acute dyspnoea with opioid-naïve patients:**

- if fast titration is necessary, we prescribe a low starting dosage of morphine, and titrate with 1–2 mg i.v. per 15 minutes, until desired effect.

**Managing dyspnoea with opioid-experienced patients** (who have been receiving opioid for pain for at least 3 weeks):

- using fast acting morphine for titration, 1/6 (or 15%) of the daily opioid dosage;
- we adjust the slow release opioid form on a daily basis as needed.

Dyspnoea patients frequently, especially with severe forms, also manifest anxiety and fear, so they also need to take a sedative, such as *lorazepam* or *midazolam*.

**WARNING:** When using opioids, it is important to prescribe a laxative to prevent constipation.

**Table 2:** Recommendations for pharmacologic treatment of other symptoms at home, at a residential care home (RCH) and in a hospital.

Symptom	Measure	Notes
Anxiety	<b>lorazepam</b> , pill, 0.5–1 mg s.l. + p.r.n./h (maximum 6–8 mg/24 h) <b>midazolam</b> , bolus doses, s.c. 2,5 mg + p.r.n. 2,5 mg/30 min	
Coughing	<b>pholcodine</b> , caps., o. susp., 10–20 mg/8 h <b>codeine</b> , pill, 30–60 mg/6–8 hours <b>morphine</b> , drops, pill, s.c., 5 mg/4 h + p.r.n. 5 mg/h (also see text)	If possible, also • for irritating cough: Panatus syrup, Sinecod • for productive cough: Prospan syrup, Fluimukan, Bisolvon.  For an exceptionally productive type, <b>hyoscine butylbromide</b> can also be used.
Pain	Depending on the severity of pain (see in text).	If pain is stable, fentanyl and buprenorphine can also be used.
Nausea	<b>metoclopramide</b> , pill, syrup, s.c., 10 mg/6 h <b>domperidone</b> , pill, 10 mg/6 h <b>haloperidol</b> , pill, drops, s.c., 0,5–1 mg/4–12 h	
Motor unrest, hallucinations and delirium	<b>haloperidol</b> , drops, s.c., 1 mg–2.5 mg p.r.n./30 min to effect, then partial dosages at 4–12 h <b>midazolam</b> , s.c., 2.5–5 mg + p.r.n./30 min to effect	Calm environment
Terminal respiratory secretions	<b>hyoscine butylbromide</b> , bolus dose, s.c. 20 mg/4 h + p.r.n./h max 120 mg/24 h	
Dry mouth	Moistening the mouth, regular mouth hygiene	Parenteral ingestion of liquid not recommended.

**WARNING:** Do not use a fan to ease dyspnoea and lower body temperature due to the possibility of virus spread through aerosol.

## 5.4 Pain

Pain is managed with regard to intensity:

- non-opioid analgesics (paracetamol, metamizole), while avoiding NASR, unless there is a clear indication for them (16).
- with weak opioids (tramadol, tramadol/paracetamol), and
- with strong opioids.

When using morphine and other opioid analgesics, we have to adhere to correct titrating and the Table Comparable opioid dosages (Table 3).

**morphine o.: s.c. = 3:1, s.c.= i.v.**

In practice this means that the s.c. dosage is 3-times lower than the o. dosage.

**WARNING:** When starting opioid treatment, do not forget the laxative.

## 5.5 Anxiety/fear/unrest

Dyspnoea often causes anxiety and fear in patients, and along with pharmacologic support, they also require an emphatic approach, consoling and encouragement. Patients with severe respiratory distress from COVID-19, especially those who opted to limit invasive treatment with ventilation, require regular and frequent assessment of conditions, and quick action for easing dyspnoea and anxiety.

*Lorazepam* or *midazolam* can be used for easing.

**Patient with dyspnoea (eased with opioids) and a moderate anxiety, with fear:**

- *Lorazepam*; tab., 1 mg + p.r.n./h, o., s.l. (dissolve in 2 ml water), maximum 6–8 mg/24 h, or
- *Midazolam*; CIVL., starting doage: 2.5–5 mg/24 h + p.r.n. 2.5 mg/30 min, s.c., i.v.

With hard to mitigate anxiety, fear or unrest, the switch to parenteral intake of drugs is needed. Because of fewer undesired side effects s.c. application is recommended.

**Table 3:** Comparable opioid dosages (oral and transdermal).

Opioid	daily dosage							
morphine (mg)	30	60	90	120	150	180	210	240
tramadol (mg)	150	300		600				
oxycodone (mg)		30		60		90		120
oxycodone/ naloxone (mg)		30/15		60/30		80/40		
hydromorphone (mg)	4	8	12	16	20	24	28	32
tapentadol (mg)		100	200	300		450		
fentanyl TDS (µg/h)	12.5	25		50		75		100
buprenorphine TDS (µg/h)		35		52.5		70		105

**Patient with severe dyspnoea and severe anxiety, fear and/or unrest:**

- *Midazolam*, CIVI (usually in combination with morphine), starting dosage 5–10 mg/24 h + p.r.n. 2.5 mg/30 min, s.c., or
- *Midazolam*, solution for inj., bolus dosage, 2.5–5 mg/4 h + p.r.n. 2.5 mg/30 min, s.c.

## 5.6 Nausea

Nausea can be the result of a disease, irritating cough and/or use of drugs. It can be eased with metoclopramide, domperidone or haloperidol.

- *Metoclopramide*, tab., syrup, 10 mg/6 h, o., s.c., i.v.;
- *Domperidone*, tab., 10 mg/6 h, o.;
- *Haloperidol*, drops, solution for inj., 0.5–1 mg/4–12 h, o., s.c.

## 5.7 Unrest/delirium/hallucinations

COVID-19 patients are often upset and can be delirious.

There are several reasons for this, with the most frequent being an infection, hypoxaemia and/or isolation. We are always looking for sources of discomfort that we can affect quickly and causally, e.g., pain, constipation, or urine blockage.

It is important to quickly recognise and treat immediately.

We use nonpharmacologic and pharmacologic methods of treatment.

Nonpharmacologic measures include assessment and treatment of all possible cause factors, ensuring a peaceful environment and focusing on the patient's other needs.

Among pharmacologic measures used for motor unrest are *lorazepam* and

*midazolam*, and for confusion and hallucinations *haloperidol*.

**Motor unrest:**

- *Lorazepam*; tab., 0.5–1 mg + p.p./h until desired effect, s.l., o., or
- *Midazolam*; solution for inj., bolus dosage, 2.5–5 mg + p.r.n./30 min to effect, s.c., i.v., or
- *Midazolam*; CIVI., starting dosage: 10 mg/24 h + p.r.n. 2.5 mg/30 min, s.c.

**Unrest with hallucinations, confusion:**

- *Haloperidol*; drops, solution for inj., 1–2.5 mg + p.r.n. 1–2.5 mg/30 min to effect, then partial dosages at 4–12 h, or
- *haloperidol*; CIVI, starting dosage 2.5–5 mg/24 h + p.r.n.. 2.5 mg, s.c.

## 5.8 Dry mouth

We use preparations for moistening the mouth and regular oral hygiene.

## 5.9 Terminal respiratory secretions (death rattle)

With COVID-19 patients, respiratory secretions can occur near end of life. Early use of drugs is important for reducing secretion, thereby preventing the development of the rattle. After rattle manifests, no measures can reduce it.

Parenteral ingestion of liquid and potential aspiration increases the secretion in the breathing apparatus in patients who are dying.

Death rattle is managed using pharmacologic and nonpharmacologic approaches.

A nonpharmacologic approach is changing the patient's body position, which somewhat and temporarily manages the rattle. We always opt for positions that are comfortable for the patient.

Pharmacologically, rattle is most often managed by using *hyoscine butylbromide*.



- *Hyoscine butylbromide*; CIVI., 20–120 mg/24 h + p.r.n. 20 mg/1 h, maximum 120 mg per day, s.c., i.v.;
- *Hyoscine butylbromide* (at RNC or at home); bolus dosage 20 mg/4 h + p.r.n. 20 mg/1 h to effect, maximum 120 mg per day, s.c., i.v.

Alternatively:

- *Glycopyrronium bromide*; continuous 0,6–1,0 mg/24 h + p.r.n. 0,2 mg/2 h, s.c., i.v.
- *Hyoscine*, patch, 1.5 mg per 3 days, dermal
- 0,5 % –1 % *atropine*, drops, 2–3 drops/6 h.

### 5.10 Palliative sedation

Towards the end of their life, COVID-19 patients may need deep continuous sedation for easing the advancing dyspnoea, fear, anxiety, and unrest, and this provides them with a calm passing. Palliative sedation is appropriate when other recommended methods cannot mitigate these symptoms.

Palliative sedation has to be deliberate, well prepared, and always carefully documented. After initiating palliative sedation, the symptoms of distress and the level of sedation have to be assessed on a regular basis. Consequently, we seldom administer it in the home environment. A physician who is considering the need for palliative sedation in a hospital, RCH or at home, should consult a physician with specific knowledge of palliative care.

The drug of choice is *midazolam* in the starting dosage of 10–20 mg/24 h, s.c. or i.v. + dosages p.r.n. In those cases when dosages above 60 mg/24 h are required, a neuroleptic must be added (*haloperidol*).

## 6 Mitigating the symptoms of COVID-19 patient by their place of treatment

### 6.1 Mitigating symptoms of patients at home during the period of infections with the SARS-CoV-2 virus

If we care for patients at their home, care is provided by family doctors, community nurses, emergency room physicians, and where available, mobile palliative teams. At the request of a patient and their family, hospice workers may be included in the support.

The basic method of administering drugs at the home is oral, transdermal, rectal, or subcutaneous bolus or continuous administration with an elastomer pump. Intravenous injection at the home is generally not possible (Table 1 and 2).

It is important that patients have a sufficient amount of drugs available that they can use according to the physician's instructions regarding dosages and methods of administration.

**WARNING:** With patients who require assistance in taking oral medication, there is an increased risk for contact and droplet transfer of infection.

With uncontrollable cough and excretion of secretion parenteral administration is recommended in the form of subcutaneous infusion with controlled flow or a pump (at home, RCH), or intravenous injection (at RCH, hospital).

## 6.2 Mitigating symptoms of patients at RCH during the period of infections with the SARS-CoV-2 virus

Residents of RCHs frequently have several chronic diseases, which along with their advanced age means a higher risk for a more severe clinical progress of COVID-19, and a higher probability of a fatal outcome. When the viral infection is at first mild, it may suddenly turn severe. Therefore, it is very important to ensure constant monitoring of patients and continuous easing of infection symptoms and providing all other palliative measures for managing basic chronic diseases.

The basic method of administering drugs at RCH is oral, transdermal, rectal, or subcutaneous bolus, or continuous administration with an elastomer pump, or infusion with controlled flow. Intravenous injection is also possible when the patient already has an intravenous path and all required experts are present (Table 1 in 2).

Subcutaneous infusion is appropriate with gradual titration of drug doses and is set with systems for managing the flow to ml/h. Infusion has a mixture of several required medications at the same time, and medical staff provide of any additional doses, if needed. For bolus subcutaneous administration, a subcutaneous cannula can be attached about two fingers below the collar bone.

Some patients have been using drugs via an elastomer pump for managing symptoms of other diseases. Additionally, required drugs for managing COVID-19 symptoms are added to their pump.

If a patient is dying at the RCH, it is recommended that even with a prohibition of visitors, family members are permitted to visit them when adhering to all required personal protection measures. All other required support should also be provided

(psychological and spiritual). Hospice also provides compassionate telephone conversations which are a great help.

## 6.3 Mitigating symptoms of patients at hospital during the period of infections with the SARS-CoV-2 virus

Patients who require hospital treatment for COVID-19 usually have acute respiratory insufficiency from pneumonia. Typical signs are dyspnoea, cough, frailty and fever. Additional signs that have been described include anxiety, panic, unrest, and delirium. With patients who are not treated at intensive care, the respiratory failure can worsen quickly, and therefore regular monitoring of symptoms and quick response are needed. The prognosis for dying with these patients (without invasive ventilation) is limited to a few hours or days.

The basic method of administering drugs in a hospital is generally oral, transdermal, rectal or subcutaneous bolus, or with continuous infusion with controlled flow, with elastomer or electronic pump, as well as intravenous, when needed or when this is the optimum solution for the patient (Tables 1 and 2).

Because hospitals generally treat the patient with the most severe levels of dyspnoea (or pain), infusions with controlled flow are often used on them. Morphine is the opioid of choice, while other opioids are used with regard to the comparative (equianalgesic) opioid dosages (Table 3). Table 4 shows examples of morphine preparation for infusions with controlled flow, either subcutaneous or intravenous. More detailed instruction for preparing infusions, magistral formulae (compounding) for morphine drops and elastomer pumps and for preparing perfusors are available in a longer version of these

**Table 4:** Examples of preparing morphine for continued infusion.

Patients who had not used morphines before	Patients who already use morphine preparations (example: 300 mg o.)
<b>50 mg morphine in 50 ml 0.9% NaCl</b>	<b>100 mg morphine in 50 ml 0.9% NaCl</b>
Concentration 1 mg/m <sup>2</sup>	Concentration 2 mg/m <sup>2</sup>
<b>We begin with an infusion of 0.5 mg/h</b>	<b>We begin with an infusion of 0.5 mg/h</b>

recommendations on the website of the Slovenian Association for Palliative and Hospice Care (6).

### 6.4 Admittance to hospital

Every patient admitted to the hospital requires an assessment of the probability of the need to escalate care with regard to their whole clinical picture, regardless of the current state of the healthcare system (Figure 1). This is conducted by the admittance team individually for every patient, and they also consider potential escalation and the need for invasive measures (Table 5).

Different medical associations recommend different steps. Some recommend that patients with acute respiratory failure from COVID-19 receive early endotracheal intubation even before deciding to limit medical care, while others recommend differently.

Timely decision-making on possible limitation of medical care makes it possible for patients with severe comorbidities to not receive medical care that is not sensible or that could cause additional distress to an individual. This allows them to remain at the location of their choosing. Pro and contra decisions regarding certain medical measures must be deliberate and documented. They represent a core ethical challenge for the responsible physician.

### 6.5 Effective communication

In palliative care, we pay special attention to communication and collaboration

with the patient, their family, providers of palliative care and the staff. Under the conditions of the SARS-CoV-2 pandemic and epidemic, this is even more important and demanding because of a series of interaction limitations; however, it is still possible. In a crisis situation and in isolation, the patients and their relatives are more concerned, while the hospital staff often does not have enough time. The standard principle of communication is generally moved to telephone calls (17). When we notice emotional distress (fear, anger, sadness), we recognize that it is justified, because this is a very difficult situation, then compassionately offer information that can help clear up the insecurities and worries. When only telephone information is available, it is important that the staff report on everyday tasks and interactions that the patient was or was not capable of performing, and not only the clinical data on the condition of their disease, as this can help present the condition that relatives could notice when visiting the patient. It is also important to ask the relatives about the expectations and worries in order to discover and clear up any possible false expectations about the future course of the disease. We provide compassion and support.

## 7 Conclusion

Recommendations are a contribution of the members and colleagues of the Slovenian Association of Palliative and Hospice Care (family physicians, oncologists, anaesthesiologists, neurologist, haematologist,

**Table 5:** Specific questions regarding the level of care (NIV: non-invasive ventilation).

CPR	yes/no
Endotracheal intubation	yes/no
Intensive therapy and care	yes/no
NIV/high oxygen flow	yes/no

specialists for palliative care and emergency medical assistance) as a guideline in palliative care of all patients who need it, regardless of where the care is provided and with an emphasis on the symptoms that crop up more frequently with COVID-19 patients. Under the current conditions, we can expect unpredictable situations and the need for palliative care, and in that light, the recommendations will be updated as the situation develops.

## 8 Abbreviations and acronyms

- COVID-19: the coronavirus disease of 2019
- RCH: residential care home
- mg: milligram
- mcg: microgram
- p.r.n.: as needed (pro re nata)
- o.: orally, through the mouth
- s.c.: subcutaneously
- i.v.: intravenously
- s.l.: sublingual
- tab: tablet
- caps: capsule
- o. susp.: oral suspension
- CIVI: continuous intravenous infusion
- NIV: non-invasive ventilation
- Opioid: a substance that causes analgesia by activating the opioid receptor. The basic opioid in palliative care is morphine.

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