Summary of Input from the Canadian Society of Palliative Care Physicians

Re Drug shortages and mitigation strategies

April 27, 2020

Excerpts from CSPCP brief to HESA (submitted April 22, 2020)

1. **More dedicated community resources for palliative care in community settings**, to provide humane, dignified care for people who do not need or want to be in the hospital. Settings include peoples' homes, long term care (LTC) and assisted living facilities, hospices, prisons, reserves, homes for adults with disabilities, and "street" services to people experiencing homelessness (including)…

b. Sufficient supply of drugs and delivery mechanisms

1. Federal monitoring of available supply of injectable drugs, management of shortages of medications needed for end of life care such as midazolam, lorazepam, methotrimeprazine, phenobarbital, fentanyl, hydromorphone, and morphine; equitable distribution including community.

2. Extend medication coverage to include a broader array of drugs than are normally used at end of life due to shortages (e.g., loxapine, phenobarbital).

3. Obtain and distribute more infusion pumps and/or syringe drivers and the associated lines and subcutaneous medication sets. Needed because higher doses and continuous infusions of medications are required to manage the symptoms of COVID-19.

2. **Access to appropriate medications for management of severe symptoms in all settings.**

   a. Some medications are available in the hospital (e.g. injectable methotrimeprazine) but not in other settings.
   b. Some medications, such as midazolam and fentanyl, are being reserved only for ICU and not available in other units and settings despite being required to care for patients with palliative needs inside and outside of the ICU.
   c. There is overlap in medications required to manage symptoms in ICU, including for withdrawal of life sustaining measures, such as midazolam and fentanyl. Where possible, alternative sedative medications such as propofol and dexmedetomidine may be used in the ICU.
   d. Guidance for clinicians in all care settings is needed to ensure equitable access for all, as well as ways to reduce waste when medications are used.
   e. Guidelines are needed to permit reuse of unopened injectable medication vials so medications in short supply are not needlessly wasted.
   f. Ensure all nurses are trained in subcutaneous medication delivery.

Why should phenobarbital and methotrimeprazine be designated Tier 3?

- Methotrimeprazine is not available in some settings, short supply in others, especially in community.
    - Methotrimeprazine is the standard of care as a first or second line agent. It is used for delirium, anxiety, agitation, nausea, and dyspnea and in conjunction with other medications.
    - Core medication for COVID-19, listed in everyone's symptom guidelines and COVID-19 symptom kits
    - Can be delivered subcutaneously and therefore appropriate choice for end of life.
    - Has many indications, including nausea, agitation, sleep disturbance, and anxiety for patients with or without COVID-19.
- Phenobarbital
    - Alternative sedative for use in palliative care and ICU.
    - One of multiple medications required to treat intractable symptoms.
    - Particularly useful because in patients with comorbidities including renal failure. Since quite a few COVID-19 patients have organ failure; phenobarbital may be first choice.
    - Can be given subcutaneously.
    - Used to prevent and treat seizures in people in all settings (including community settings) who can't take oral anti-seizure meds at end of life.
- Both drugs:
    - With COVID-19, the symptoms are so significant that higher doses of many medications are sometimes needed. Either of these drugs can be added on top of the first line drugs when first line alone isn't sufficient.
    - Favoured by palliative care because usually multiple indications. Reduces risk of medication errors and polypharmacy.

Important considerations

- Need will be different depending how many cases they have in an area and whether there are surges.
- If shortages, substitutions may be required.
- Toronto is doing mathematical modeling of drug availability and usage, including what would happen with a surge, and how it correlates
- Kingston region – Normal symptom response kits allow for rapid symptom management while someone is waiting for help. Only a small subset of the drugs are used, the rest is wasted because there's no return system. Now, a narrower kit just developed specifically for COVID-19 with smaller amounts, fewer drugs, and specific guidelines to reduce wastage.
- At fastest, there is a 5-hour wait for the kit – too long for a person with COVID-19 if they are deteriorating
    - Need a way to deliver kits quickly
    - RNs are not always allowed to pick up kits. (union rules) – could it be changed? NPs are allowed.
    - Could there be a mobile kit that isn't patient specific? E.g., pre-set emergency kit that stays with the nurse. Ready to go and be taken to the house (as opposed to leaving one at the house, just in case, and then not needing it / wasting it)
- Midazolam – may be suitable and available, but to administer it, it needs a mechanism such as a continuous infusion pump and associated lines. Also running out of alcohol wipes. Continuous infusions and pumps require less nursing intervention once set up, therefore allowing each nurse to manage a larger case load of patients.
- There are uses outside of palliative care, too. Pharmacist involvement is important.

Issues raised with NAPRA (Unresolved)

Medications dispensed to a patient - even when unopened (e.g., Vials of injectable medications in an unused symptom response kit that was delivered to a patient's home) **cannot be returned and re-dispensed as per pharmacy standards.** They are disposed of.

Medications in pre-filled syringes need to be allowed to be used for longer than 24 hours in the context of end of life care and subcutaneous administration. We were not able to resolve this with NAPRA despite our advocacy and it continues to be a problem in many areas of the country. It wastes medications unnecessarily and requires nursing support on a daily basis that is not possible in many places. **This could be avoided by exempting PC meds at end of life from this requirement.**