Symptom management for adult patients with COVID-19 receiving end-of-life supportive care outside the ICU*

BEFORE enacting these recommendations PLEASE clarify patient's GOALS OF CARE.
These recommendations are consistent with: DNR, AND, no ICU transfer, comfort-focused supportive care.

Suggested tools to assist with goals of care conversation:

- From Seattle MDs: COVID-19 Conversation Tips (http://bit.ly/SeattleVitalTalkCOVID19)
- From Providence Health Care: Serious Illness Conversation Guide with high risk COVID-19 patients: Tool and video tutorial.
- From the PATH program: Worksheet to help providers discuss goals of care with LTC residents/SDMs in preparation for COVID-19 pandemic

OPIOIDS help relieve acute respiratory distress. ALL relieve dyspnea & can be helpful for cough -*codeine is not recommended*.

Patient **NOT** already taking opioids **("opioid-naive")**

Begin at low end of range for frail elderly

Start with PRN *but* low threshold to advance to q4h scheduled dosing:

MORPHINE:

2.5 - 5 mg PO ***OR*** 1 - 2 mg SQ/IV
q1h PRN *(SQ/IV can be q30min PRN)*,
if >6 PRN in 24h, MD to review

HYDROMORPHONE
0.5 - 1 mg PO ***OR*** 0.25 - 0.5 mg SQ/IV
q1h PRN *(SQ/IV can be q30min PRN),*
if >5 PRN in 24h, MD to review

TITRATE UP AS NEEDED

If using 5 PRNs in 24h,
consider dosing at q4h REGULARLY
(q6h for frail elderly)
***and* continue a PRN dose**

Also consider PO solution for cough
(see cough algorithm on page 22 of the B.C. symptom management guidelines for cough)

Patient already taking opioids

Continue previous opioid,
consider increasing by 25%

To manage
breakthrough symptoms:

Start opioid PRN at 10% of total daily (24h) opioid dose

Give PRN: **q1h PRN if PO, q30min if SQ**

See guideline for conversion between opioids*

FOR ALL PATIENTS:

OTHER MEDICATIONS: Although Opioids are the mainstay of dyspnea management, these can be helpful adjuvants:

For severe SOB/anxiety:
MIDAZOLAM
1 - 4 mg SQ q30min PRN,
max 3 PRN/24h,
if max reached and not settled call MD

For associated anxiety:
LORAZEPAM
0.5 - 1 mg SL q2h PRN,
max 3 PRN/24h,
MD to review if max reached

For agitation/restlessness:
METHOTRIMEPRAZINE
2.5 - 10 mg PO/SQ q2h PRN,
max 3 PRN/24h,
MD to review if max reached

Respiratory secretions/congestion near end-of-life:
Prepare the family & bedside staff: not usually uncomfortable, just noisy, due to patient weakness/inability to clear secretions. Change in positioning can often help.
All anti-cholinergic medications have limited benefit.
If needed, consider **Glycopyrrolate** 0.4mg SQ q4h PRN for upper resp. congestion
If severe lower resp. congestion consider furosemide 20mg SQ q2h PRN & monitor response

For Crisis Respiratory Failure, follow pre-printed order *Actively Dying Patient with Known or Suspected COVID-19 not receiving intubation*

Ensure comfort and dignity as key priorities as patients approach end of life and ensure written orders reflect this. Unmanaged or poorly managed symptoms at the time of death will add to distress of patients, family members & bedside staff.

OXYGEN: *Supplemental Oxygen is generally not beneficial for someone unless they are hypoxic. Other measures for dyspnea relief should be sought. With suspected or confirmed COVID-19 cases do not use fans. Other non-pharmacological management include cooling the room, clear line of sight to a window or applying a cool facecloth.*
NEBULIZERS: *With suspected or confirmed COVID-19 cases nebulized aerosols are not to be used due to risk of aerosolizing the virus. Alternatives such as metered dose inhalers with spacers (with mask for the frail/elderly) should be used.*
HYDRATION: *Artificial hydration (IV fluids) is not indicated at the end of life as it can lead to excessive fluid collections in unwanted places. Attention to mouth care can eliminate or minimize thirst.*

These recommendations are to be used as a reference and do not supersede clinical judgement. We have attempted to decrease complexity to allow barrier-free use in multiple settings as part of the COVID-19 pandemic response. Evidence supports that appropriate opioid doses do not hasten death in other conditions like advanced cancer or COPD; dosing should be reassessed as patient's condition or goals of care change. This document is provided "as is" to allow immediate use - it may continue to evolve as new information emerges. Please refer to NSHA's COVID-19 HUB for most up to date version. ***Version 3: April 3, 2020.***

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*Adapted with permission from the symptom management document developed by BC Palliative Care MDs, pharmacists & allied health and additional input from and approval by the NSHA COVID-19 Clinical and Medical Advisory Committee. See BC Centre for Palliative Care Symptom Management Guidelines for more comprehensive resource for palliative care symptom management.