

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

adapted from BC Centre for Palliative Care Guidelines* with input from Palliative Care MDs & pharmacists. Thank you to all who helped!

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

Suggested tools to assist with conversation:

From Seattle MDs: COVID-19 Conversation Tips (<http://bit.ly/SeattleVitalTalkCOVID19>)

Serious Illness Conversation Guide (<http://bit.ly/SeriousIllnessConversationGuide>)

Communicating Serious News (UpToDate; requires login <http://bit.ly/CommunicatingSeriousNews>)

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

OPIOIDS

(ALL relieve dyspnea & can be helpful for cough - *codeine is not recommended*)

Opioids help relieve acute respiratory distress & agitation, contribute to energy conservation

Begin at low end of range for frail elderly

Start with PRN *but* low threshold to advance to q4h / q6h scheduled dosing: Avoid PRN = "Patient Receives Nothing"

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 >6 PRN in 24h, MD to review

TITRATE UP AS NEEDED

If using >6 PRNs in 24h, consider dosing at q4h REGULARLY (q6h for frail elderly) *and* continue a PRN dose

Also consider (see guidelines*):

PO solution for cough

eg. dextromethorphan, hydrocodone
antinauseant eg. metoclopramide SQ
laxative eg. PEG / sennosides

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 further assistance including telephone support please contact your local Palliative Care team

FOR ALL PATIENTS: OTHER MEDICATIONS

Opioids are the mainstay of dyspnea management, these can be helpful adjuvants

For associated anxiety:

LORAZEPAM

0.5 - 1 mg SL q2h PRN,
max 3 PRN / 24h,
MD to review if max reached

For severe SOB / anxiety:

MIDAZOLAM

1 - 4 mg SQ q30min 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

Advise family & bedside staff: not usually uncomfortable, just noisy, due to patient weakness / not able to clear secretions

Consider glycopyrrolate 0.4mg SQ q4h PRN *OR*

atropine 1% (ophthalmic drops) 1 - 2 drops SL q4h PRN

If severe consider furosemide 20mg SQ q2h PRN & monitor response

Engage with your team to ensure comfort is the priority as patients approach end of life. Please ensure written orders reflect this. Unmanaged symptoms at time of death will add to distress of patients, family members & bedside staff.

These recommendations are for reference and do not supercede clinical judgement.

We have attempted to decrease complexity to allow barrier-free use in multiple settings.

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.

*BC Centre for Palliative Care Guidelines

<http://bit.ly/BCCentreSymptomManagementGuidelines>

Latest version of this document

(link may not be live yet, keep checking):

<http://bit.ly/LatestCOVIDSxDoc>