Respiratory Distress and symptom management for adult patients with COVID-19 receiving end-of-life supportive care outside of the ICU

adapted with permission from BC Centre for Palliative Care Guidelines*

BEFORE enacting these recommendations
PLEASE identify patient's GOALS OF CARE

These recommendations are consistent with: DNR, no ICU transfer and comfort-focused care in hospital, LTC or Home with no hospital transfer

Suggested tools to assist with conversation: **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)

All below are STARTING doses. COVID-19 symptoms may advance quickly. Be prepared to escalate dosing.
Consider dose ranges to give frontline staff capacity for urgent clinical decision-making as needed.

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

Opioids

All relieve dyspnea & can be helpful for cough

Begin at low end of range for frail elderly

Start with PRN but low threshold to Advance to q4h scheduled dosing

MORPHINE
2.5-5mg PO **OR** 1-2mg SQ/IV q1h PRN (SQ/IV can be q30min PRN)
If >3 PRN in 24h, MD to review

HYDROMORPHONE
0.5-1mg PO **OR** 0.25-0.5mg SQ/IV q1h PRN (SQ/IV can be q30min PRN)
If >3 PRN in 24h, MD to review

TITRATE UP AS NEEDED

If using > 3 PRN in 24h, consider q4h scheduled dosing and continue q1h PRN dosing
(Consider q6h dosing for frail elderly or for renal impairment)

Evidence supports that appropriate opioid doses do not hasten death in conditions like COPD or advanced cancer; reassess dosing as patient's condition or level of intervention changes

Also Consider:
Laxatives e.g. PEG/sennosides
Antinauseants e.g. metoclopramide/haloperidol

Patient already taking opioids

Continue previous opioid
Consider increasing by 25%

SC/IV dose is ½ PO dose

To manage breakthrough symptoms:
Start opioid PRN at 10% of total daily (24h) opioid dose

Give PRN: Q1h if PO, q30min if SQ

For further assistance including telephone support, please contact your local palliative care consultant.

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 q2 - q4h PRN

SCOPOLAMINE:
0.4-0.6 mg SQ q4h PRN

ATROPINE 1% OPHTHALMIC DROPS:
3-6 drops SL/buccal q4h PRN

TRANSDERM V PATCH:
1 patch behind each ear q72h PRN

For All Patients:

Opioids are the mainstay of dyspnea management.

The following medications are helpful adjuvants for dyspnea/agitation:

LORAZEPAM
0.5-2 mg SL/SQ q1h PRN
If >3 PRN in 24h, MD to review
Consider q4-12h regular dosing. Continue PRN dosing
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MIDAZOLAM
1-5 mg SL/SQ Q30min PRN
If >3 PRN in 24h, MD to review
Consider q4h regular dosing or continuous infusion if available

Note: In frail elderly, consider adding antipsychotic to prevent benzodiazepine induced agitation

For Agitation/Restlessness:

HALOPERIDOL
0.5-1mg PO/SQ q2h PRN
If >3 PRN in 24h, MD to review
Consider regular dosing

METHOTRIMEPRAZINE
6.25-12.5mg PO/SQ q2h PRN
If >3 PRN in 24h, MD to review
Consider regular dosing

Grief and bereavement support:
Consider involving support from:
SW, spiritual care, chaplaincy

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 and bedside staff. Please insert SQ line when needed and discontinue non-essential medications. Hydration may worsen symptoms of dyspnea and may need to be discontinued. 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.

Recommendations compiled collaboratively with input from BC guidelines, Baycrest Palliative Care Team and NYGH Freeman Centre for the Advancement of Palliative Care. Version: 2020 Mar 31.