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 contributed!

BEFORE enacting these recommendations PLEASE identify patient's LEVEL OF INTERVENTION
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)

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 - *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

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

PLEASE TITRATE UP AS NEEDED

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

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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,
initial order: max 3 PRN / 24h,
MD review when max reached
consider q6-12h regular dosing

For severe SOB / anxiety:
MIDAZOLAM
1 - 4 mg SQ q30min PRN,
initial order: max 3 PRN / 24h,
MD review when max reached

MAY REQUIRE MUCH MORE
consider q4h regular dosing or continuous infusion if available

For agitation / restlessness:
METHOTRIMEPRAZINE
2.5 - 10 mg PO / SQ q2h PRN,
initial order: max 3 PRN / 24h,
MD review when max reached
consider q4h regular dosing
can also be given buccally

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 ? fluid overload 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.
Please adapt as needed for appropriate use in your population.

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 COPD or advanced cancer; reassess dosing as patient's condition or level of intervention changes.

***Latest version of this document**: (online updates may be slightly delayed) http://bit.ly/LatestCOVIDSxDoc*

***BC Centre for Palliative Care Guidelines** http://bit.ly/BCCentreSymptomManagementGuidelines

This document is provided "as is" to allow immediate use - it is continuing to evolve as we receive feedback. Thank you for your input and your understanding.
Version: 2020 Mar 25. Recommendations compiled collaboratively with input from a team of BC Palliative Care MDs, pharmacists & allied health. Feedback to katie.mcaleer@gmail.com