Symptom Management for Adult Patients with COVID-19 Receiving End-of-Life Supportive Care Outside of ICU

BEFORE enacting these recommendations PLEASE check the patient's GOALS OF CARE designation order. These recommendations are consistent with M1, M2, C1 or C2 (where death is anticipated), and symptom support is needed, alongside any medical management that might be continuing (No CPR/No ventilation/No ICU transfer will be used)

Suggested tools to assist with conversation:
Planning Ahead: https://www.albertahealthservices.ca/assets/info/ppih/if-ppih-covid-planning-with-vulnerable-patients.pdf
Streamline GCD algorithm: https://www.albertahealthservices.ca/assets/info/ppih/if-ppih-covid-19-vitaltalk-phrases.pdf
Vital Talk Tips: https://www.albertahealthservices.ca/assets/info/ppih/if-ppih-covid-19-gcd-algorithm.pdf

Developed by Calgary and Edmonton Zones PEOLC Program
Adapted with permission from Fraser Health resource

Other resources:
End-of-life care in the ED for the patient at EOL with COVID-19
https://caep.ca/wp-content/uploads/2020/03/EOL-in-COVID19-v5.pdf

AHS PEOLC
https://www.albertahealthservices.ca/info/Page14559.aspx

AHS Conversation Matters
https://www.albertahealthservices.ca/info/Page12585.aspx

OPIOIDS (for dyspnea or pain)

(all opioids relieve dyspnea & can be helpful for cough – codeine is not recommended)
Please remember to order laxatives and anti-emetics

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

Begin at low end of range for frail elderly

Start with PRN but low threshold to advance to q4h (or q6h for eGFR <30) scheduled dosing

Morphine (avoid in renal failure)
2.5 or 5mg PO OR 1.25 or 2.5mg subcut/IV q1h prn
OR
Hydromorphone
0.5 or 1mg PO OR 0.25 or 0.5mg subcut/IV q1h prn

Titrate up as needed:
If >4 prn doses in 24h, consider scheduled dosing at q4h
(or q6h for frail elderly or eGFR <30)

Patient already taking opioids

Continue with previous opioid
Consider increasing by 25%
OR
Calculate the new dose
(Add up total dose of opioid given in previous 24 hours by adding up all regular doses and all breakthrough doses & dividing that total into equal q4h or q6h doses)

Remember to calculate new breakthrough dose
= 10% of total daily
Give q1h prn

NAUSEA AND VOMITTING CONTROL (initiate when using opioid)

Metoclopramide 5 or 10mg PO/subcut/IV q2h prn
or
Haloperidol 0.5 or 1mg PO/subcut/IV q2h prn
or
Ondansetron 4 or 8mg PO/subcut/IV q4h prn

Severe Dyspnea* (In addition to opioids above)

Midazolam 2 up to 5mg subcut/IV q30min prn
AND consider palliative sedation (see Palliative Sedation Quick Tips)

*Consider palliative care consultation

AGITATION / CONFUSION / DELIRIUM CONTROL

(consider pall care consult if below not effective)

While possible causes are being investigated and/or treated, start symptom control as follows:

a) **Haloperidol** 0.5 up to 2.5mg PO/subcut/IV q8h & 0.5 up to 2.5mg q1h prn (start low)

b) If not effective after three consecutive doses, use **methotrimeprazine** 12.5mg subcut q8h & 12.5mg q1h subcut prn (more sedating).
May need to increase to 25mg doses.

RESPIRATORY SECRETIONS / CONGESTION NEAR END-OF-LIFE

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

Consider: **Glycopyrrolate** 0.4mg subcut q4h prn
Or: **Scopolamine** 0.4mg subcut q4h prn

If pulmonary edema, consider:
Furosemide 20 – 80mg subcut/IV q2h prn and monitor response

Calgary Zone

Urgent Palliative Care
24/7 Consultation & Physician On-Call

Acute Care urban:
Look in ROCA – and **page us**
→ then in SCM: enter "Palliative Care Consult"

Community or all rural sites:
Call RAAPID 403-944-4486 or 1-800-661-1700

OTHER CONSIDERATIONS FOR END OF LIFE CARE:

Vitals signs monitoring only if required for symptom management (e.g. fever)

- **Acetaminophen** 650 mg PO or PR q4h prn for fever causing discomfort
- Secaris nasal gel QID and PRN
- Methocellulose 0.5% 2 gtts per eye QID and PRN
- Oral balance QID and PRN

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 supersede clinical judgment. We have attempted to decrease complexity to facilitate use in multiple settings.

Version: April 15, 2020; Feedback to Charlie.chen@ahs.ca