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

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:

Streamlined Goals of Care Designation decision-making for COVID 19: add ink
Planning Ahead with Vulnerable Patients During Covid-19: A Conversation Tool for Clinicians: add link
COVID-ready communication skills: A playbook of VitalTalk Tips: add link

Developed by Calgary Zone 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 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 – 5mg PO or 1.25 – 2.5mg subcut/IV q1h prn
OR
Hydromorphone
0.5 – 1mg PO or 0.25 – 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 prn: q1h for PO
Q30min for subcut/IV

NAUSEA AND VOMITTING CONTROL

Metoclopramide 10mg PO/subcut/IV q4h prn
5mg PO/subcut/IV q4h prn for renal failure
or
Haloperidol 0.5 – 1mg PO/subcut/IV q4h prn
or
Ondansetron 4-8mg PO/subcut/IV q8h prn

Dyspnea (See Opioids above)

May also consider:
Fentanyl 12.5-50 micrograms subcut/IV q 15 mins prn

While palliative sedation may be considered for refractory dyspnea, pall med consultation is highly recommended.

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/NP to review if max reached

For severe **dyspnea/anxiety/agitation***

Midazolam 2 – 5mg subcut/IV q30min prn
If > 2 doses used with no effect, call MD/NP

*Consider palliative care consultation

AGITATION / CONFUSION / DELIRIUM CONTROL

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

a) Haloperidol 1 – 2.5mg PO/subcut/IV q8h and 1 – 2.5mg q1h prn
b) If sedation required, methotrimeprazine 12.5mg PO/subcut/IV q8h and 12.5 – 25mg PO/subcut/IV q1h prn
c) Subcutaneous hypodermoclysis 50cc/hr Normal Saline (only if appropriate for patient)

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

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

If fluid overload, consider:
Furosemide 20 – 80mg subcut/IV q2h prn and 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 supersede clinical judgment. We have attempted to decrease complexity to facilitate use in multiple settings.

Version: April 3, 2020; Feedback to Charlie.chen@ahs.ca