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

*Calgary Zone*

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

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

**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.

**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)

**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

**NAUSEA AND VOMITING CONTROL**

- Metoclopramide 10mg PO/subcut/IV q6h 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

- 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

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**Calgary Zone**

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> then in SCM: enter “Palliative Care Consult”

**Community or all rural sites**

Call RAAPID 403-944-4486 or 1-800-661-1700

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.