Symptom management for adult patients with COVID-19 receiving end-of-life supportive care outside of the ICU

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:
Communicating Serious News (UpToDate; requires login http://bit.ly/CommunicatingSeriousNews)

OPIOIDS
(ALL relieve dyspnea & can be helpful for cough - codeine is not recommended)
Opioids help relieve acute respiratory distress & agitation, contribute to energy conservation
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

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 consider q4h regular dosing can also be given buccally

For agitation / restlessness:
METHOTRIMEMPRAZINE
2.5 - 10 mg PO / SQ q2h PRN, initial order: max 3 PRN / 24h, MD review when max reached consider q4h regular dosing or continuous infusion if available

PLEASE TITRATE UP AS NEEDED
Also consider (see guidelines*):
PO solution for cough eg. dextromethorphan, hydrocodone antiinsectant eg. metoclopramide SQ laxative eg. PEG / sennosides

Respiratory secretions / congestion near end-of-life
Advised 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.


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