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

Adapted from the BC Centre for Palliative Care Guidelines with additional input from Palliative Care clinicians

BEFORE enacting these recommendations PLEASE clarify patient's GOALS OF CARE these recommendations are consistent with: NFR, no ICU transfer, comfort-focused supportive care

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

OPIOIDS
(ALL relieve dyspnoea
& 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 (lower dose if frail/elderly) *OR* 1-2mg IV (ONLY in the Emergency Dept) or 2.5mg SC q1h PRN *(IV/SC can be q30min PRN), if >6 PRN in 24h, Dr to review*

HYDROMORPHONE
(Use especially if eGFR <30)
0.5 - 1 mg PO *OR* 0.2-0.4mg IV (ONLY in the Emergency Dept) or 0.25 - 0.5 mg SC q1h PRN *(IV/SC can be q30min PRN), if >6 PRN in 24h, Dr to review*

TITRATE UP AS NEEDED

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

Also consider: PO solution for cough eg. Dextromethorphan (Robitussin) or Bisolvon for congestion etc, antinemetic eg. Metoclopramide etc & laxatives eg. Sennosides/Movicol etc

Patient already taking opioids

Continue previous opioid,
consider increasing by 25%

To manage breakthrough symptoms:
Start opioid PRN at 10% of total daily (24h) regular opioid dose
Give PRN: **q1h PRN if PO, q30min if SC**

See below guidelines/references for conversion between opioids*

For further assistance including telephone support please contact your local Palliative Care team

FOR ALL PATIENTS: OTHER MEDICATIONS
Opioids are the mainstay of dyspnoea management, these can be helpful adjuvants

For associated anxiety:
LORAZEPAM
0.5 - 1 mg SL q2h PRN, max 3 PRN / 24h,
Dr to review if max reached

For severe SOB / anxiety:
MIDAZOLAM
2.5-5 mg SC q30min PRN, max 4 PRN / 24h,
Dr to review if max reached

For agitation / restlessness:
LEVOMEPROMAZINE (SAS medication)
6.25-12.5 mg PO / SC q2h PRN, max 3 PRN / 24h,
Dr to review if max reached

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 hyoscine butylbromide Buscopan) 10-20mg SC q4h PRN or glycopyrrolate 0.4mg SC q4h PRN ***OR*** atropine 1% (***ophthalmic drops***) 1 - 2 drops SL q4h PRN
If severe consider furosemide 20-40mg IV/SC 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. Attempts have been made 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 advanced cancer or COPD; dosing should be reassessed as patient's condition or goals of care change.

https://fpm.anzca.edu.au/documents/opioid-dose-equivalence.pdf
http://www.instituteforhumancaring.org/documents/Providers/PSJH-Serious-Illness-Conversation-Guide.pdf
https://tgldcdp.tg.org.au.acs.hcn.com.au/topicTeaser?guidelinePage=Palliative+Care&etgAccess=true
https://www.uptodate.com.acs.hcn.com.au/contents/discussing-serious-news?search=communicating%20serious%20news (needs login)
https://bc-cpc.ca/cpc/publications/symptom-management-guidelines/
https://www.capc.org/toolkits/covid-19-response-resources/