Symptom Management for Adult Patients with COVID-19 Receiving END-OF-LIFE SUPPORTIVE CARE Outside of the ICU

YOU MUST HAVE A GOALS OF CARE DISCUSSION WITH PATIENT/SDM PRIOR TO INITIATING RECOMMENDATION
These recommendations are consistent with comfort-focused supportive care
Please refer to: https://www.speakupontario.ca/ for resources to support Goals of Care Discussions

All below are STARTING doses. COVID-19 symptoms may advance quickly. Be prepared to escalate dosing.
Consider dose ranges to give frontline staff capacity for urgent clinical decision-making as needed.

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

Mild Dyspnea/Respiratory Distress
Start with PRN dosing, but low threshold to change to scheduled q4h dosing

Moderate to Severe Dyspnea/ Respiratory Distress
Start with scheduled q4h & PRN dosing or may consider continuous infusion if available

Morphine 1-2.5 mg SQ/IV q30min PRN

Hydromorphone 0.25-0.5 mg SQ/IV q30min PRN

If > 5 PRN in 24h, MD to review & consider scheduled dose or increase in already scheduled dose
If changing to a scheduled q4h dose, CONTINUE PRN dose

Titrate up as needed

Also Consider:
Laxatives e.g. PEG/sennosides
Antinauseants e.g. metoclopramide/ haloperidol
PO solution for cough e.g. dextromethorphan, hydrocodone

Patient already taking opioids

Mild Dyspnea/ Respiratory Distress
Continue previous opioid, consider increasing by 25%

Moderate to Severe Dyspnea/ Respiratory Distress
Continue previous opioid, consider increasing by 25-50%

SC/IV dose is ½ PO dose

To manage breakthrough symptoms:
Start opioid PRN at 10% of new 24h opioid dose, q30min SQ PRN

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

Grief and bereavement support: Consider involving Social Work, and/or spiritual care.

For All Patients: Adjuvant Medications

Associated anxiety:
Lorazepam 0.5-1 mg SL/SQ q2h PRN
If > 3 PRN in 24h, MD to review & consider scheduled q6-12h & q2h PRN dosing

Agitation/Restlessness:
Haloperidol 0.5-1mg PO/SQ q2h PRN
If >3 PRN in 24h, MD to review & consider regular dosing

Methotrimeprazine 2.5-12.5 mg SQ/IV q2h
If > 3 PRN in 24h, MD to review & consider scheduled q4h & q2h PRN dosing

Severe dyspnea/Anxiety:
Midazolam 1-5 mg SQ/IV q30min PRN (initial dosing)
If > 3 PRN in 24h, MD to review & consider scheduled & PRN dosing or continuous infusion if available for symptom management (not sedation)

For difficult or refractory symptoms, please consult Palliative Medicine.

Rapid titration or Continuous Palliative Sedation Therapy (CPST) may be needed. Please refer to specific CPST guideline.

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:
Glycopyrrolate 0.4mg SQ q2 - q4h PRN
Scopolamine 0.4-0.6 mg SQ q4h PRN
Atropine 1% (ophthalmic drops) 3-6 drops SL/buccal q4h PRN

If fluid overload, consider furosemide 20mg SQ q2h PRN & monitor response. Consider inserting foley catheter

WARNING

Where possible, avoid use of the following as they may generate aerosolized COVID-19 virus particles and increase the risk of infecting healthcare providers, and family members.

- Oscillatory devices (Fans)
- Oxygen Flow greater than 6L/min
- High-flow nasal cannula oxygen
- Continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BiPAP)
- All nebulized treatments (bronchodilators, epinephrine, saline solutions, etc)
- Deep airway suctioning (this does not include oral suctioning)
- Bronchscopy and tracheostomy

* **These recommendations are for reference and do not supersede clinical judgment**
* **Evidence supports that symptom-guided opioid dosing does not hasten death in other conditions like advanced cancer or COPD**
* **Reassess dosing as patient's condition or level of intervention changes**

Adapted with permission from the BC Centre for Palliative Care Guidelines.
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Ontario Palliative Care Network

Ontario Health