Managing Respiratory and End-of-life Symptoms for Frail Elderly Patients with COVID-19

adapted from BC Centre for Palliative Care Guidelines with permission

BEFORE enacting these recommendations PLEASE clarify patient's GOALS OF CARE as these recommendations are consistent with: DNR, no hospital transfer, symptom control and supportive care in place.

Suggested tools to assist with conversation: ***COVID-19 Conversation Tips*** (http://bit.ly/SeattleVitalTalkCOVID19) **and Serious Illness Conversation Guide** (http://bit.ly/SeriousIllnessConversationGuide)

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-naïve)

OPIOIDS

(ALL relieve dyspnea)

Begin low dose for frail elderly

Start with PRN but low threshold to advance to q4h scheduled dosing. SQ is the preferred route of administration.

MORPHINE
1-2 mg SQ q1h PRN.
If > 3 PRNs in 24h, MD to reassess.

HYDROMORPHINE
0.25-0.5 mg SQ q1h PRN.
If > 3 PRNs in 24h, MD to reassess.

TITRATE UP AS NEEDED.

If using > 3 PRNs in 24h, consider dosing at q4h ATC (around the clock), with continued q1h prn dose.

Also consider the need for supplemental oxygen, laxatives (e.g. PEG/sennosides) and anti-nausea medication (eg. metoclopramide)

Patient already taking opioids

Continue previous opioids, **consider increasing by 25% and switching to SQ route.***

To manage breakthrough symptoms: **Start opioid PRN at 10% of total daily (24h) opioid dose and schedule at q1h PRN. Use the SQ route.**

*Remember that the SQ dose is ½ the PO dose.

For further assistance including telephone support, please contact your local Palliative Care Consultant.

Respiratory secretion/ congestion at the end-of-life

Advise family and bedside staff: not usually uncomfortable, just noisy due to patient weakness in not being able to clear secretions.

Consider **glycopyrrolate** 0.4mg SQ q4h PRN. If volume overload, consider furosemide 20mg SQ q2h PRN & monitor response. Also consider discontinuing IV/SQ hydration.

Grief and Bereavement Support: *Consider involving the support of SW, Spiritual Care, or another trained clinician. Mobilize virtual support.*

FOR ALL PATIENTS:
These medications can be helpful adjuvants:

For associated anxiety**:
LORAZEPAM
0.5-1 mg SQ q1h PRN.
If > 3 PRNs in 24h, MD to reassess. Consider regular dosing.
** Lorazepam also effective as an adjuvant for dyspnea.

For agitation/restlessness without the need for sedation:
HALODPERIDOL
0.5-1 mg SQ q2h PRN.
If > 3 PRNs in 24h, MD to reassess. Consider regular dosing.

For agitation/restlessness with the need for sedation:
METHOTRIMEPRAZINE
2.5-10 mg SQ q2h PRN.
If > 3 PRNs in 24h, MD to reassess. Consider regular dosing.

For severe/refractory dyspnea/anxiety:
MIDAZOLAM
1-5 mg SQ q30min PRN, initial order: **MAY REQUIRE MUCH MORE.** Consider regular dosing or continuous infusion if available.

Engage with your team to ensure comfort is the priority as patients approach end of life. Please ensure orders reflect this. Unmanaged symptoms at time of death will add to distress of patients, family members and bedside staff. Families will require frequent updates. Consider discontinuing all non-essential medications and use the SQ route for those essential medications where possible. These recommendations are for reference and do not supersede clinical judgement. This document is provided "as is" to allow immediate use. Please provide feedback to gperri@baycrest.org

Baycrest | University of Toronto