SYMPTOM MANAGEMENT for COMMUNITY and LONG TERM CARE ADULT PATIENTS with COVID-19

Adapted from BC Center for Palliative Guidelines with input from Palliative Care MDs at Eastern Health Corporation

Before starting any of these interventions, ensure that appropriate discussion and documentation around Goals of Care with the patient and/or substitute decision maker has taken place.

DYSPNEA and COUGH

for opioid naive patient

MORPHINE: 2.5 - 5 mg oral or 1 - 2.5 mg subcut q1h prn
HYDROMORPHONE: 0.5 -1 mg oral or 0.25 - 0.5 mg subcut q1h prn

Begin at low range for frail elderly.
If greater than 6 doses in 24 hours, change to q4h regularly and continue prn dosing at q1h.
For frailty or renal impairment, change to q6h regularly and continue prn dosing at q2h.

Symptoms may progress rapidly, be prepared to titrate up quickly. If patient cannot tolerate a further increase, for example, that neurotoxicity symptoms develop (hyperalgesia, myoclonus, seizure, hallucination), then reduce the opioid dose and see below for ***other medications for dyspnea****, or proceed to* ***palliative sedation****.*

for patients already taking opioids

Continue current opioid dose and titrate up by 25%
Breakthrough doses q1h prn (or q2h prn for reasons already stated) calculated at half the regular dose
Refer to guidelines for conversion between opioids

Other Medications for Dyspnea

These medications may be added on as adjuvants

LORAZEPAM: 0.5 - 2 mg subling q2h prn for anxiety
MIDAZOLAM: 2.5 - 5 mg subcut q15min prn for severe anxiety/agitation

This document is intended as a guideline and should not supersede clinical judgement

SYMPTOM MANAGEMENT for NON-INTUBATED ADULT PATIENTS with COVID-19

PALLIATIVE SEDATION

Palliative sedation may be required if symptoms are refractory and deemed to be irreversible.

(agitated delirium, dyspnea, hemorrhage, uncontrolled seizure, pain are common indications)

Ensure that a **DNR** is in place. Stop all unnecessary medication. Reassure family that CPR will be of no benefit and that sedation will not shorten life, but will ensure a peaceful death.

MIDAZOLAM: 10 mg subcut q4h regularly ***and*** 2.5 - 10 mg q15 min prn
if not sufficient to achieve full sedation, may double dose

METHOTRIMEPRAZINE: 25 - 50 mg subcut q4h regularly and 25 mg q1h prn
to be **added** if Midazolam not sufficient on its own
higher doses of methotrimeprazine not likely to of benefit

PHENOBARBITAL: 60 - 120 mg subcut q8h regularly
May be added to the above medications or could be 2nd line if patient is at risk of seizure

RESPIRATORY SECRETIONS AT END OF LIFE

GLYCOPYRROLATE: 0.4 mg subcut q1h prn and/or
SCOPOLAMINE: 0.6 mg subcut q1h prn
or
ATROPINE 1% ophthalmic ggts: 1-2 ggts subling q1h prn if scopolamine unavailable.

Nebulized medication and Suctioning are **NOT** recommended due to droplet spread

If patients appear to be resistant to these options, please contact your local palliative care physician or a member of the Pain and Symptom Management Team at the Palliative Care Unit with Eastern Health Corporation:

Weekdays 8:30 - 4:30: 777-7303 (phone) or 777-8970 (Fax)

After hours and weekends: 777-8610
PCU Nursing Station - will connect you with MD on call

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