Beth Israel Lahey Health
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Comfort Focused Care for Patients with Suspected/Confirmed COVID-19

This document is intended as a supplement to the existing CG-28 Guidelines for Interdisciplinary Comfort Focused End-of-Life Care, and the associated Comfort Focused Care order set in POE → Enter orders → General Care → Comfort Focused Care

DYSPNEA, RESPIRATORY DISTRESS

Order non-pharmacologic interventions using the orderset, with emphasis on:

- Positioning for patient comfort
- Coaching slow, deep breathing
- Cool washcloth to face (believed to relieve dyspnea by stimulating trigeminal nerve)

Consider pharmacologic interventions:

OPIOIDS

General principles

- Opioids are the first-line medication choice for dyspnea.
- Oral opioids have a slower time to peak but last longer, and intravenous opioids reach peak faster but shorter duration of action (see table below). Choose IV bolus for rapid relief of acute/severe symptoms.
- If the patient lacks IV access, avoid placement of an IV catheter unless they are requiring high dose opioids. Instead use concentrated PO or subcutaneous (SQ) medication administration. ***Please consult Palliative Care p32502 for assistance.***

Medication	Time to peak	Duration of Action
Oral opioids	30-60 min	3-4 hours
IV morphine/hydromorphone	10-15 min	1-2 hours

Oral opioids

Difficulty swallowing/somnolent/obtunded, pick one **concentrated** solution:

- Morphine sulfate (concentrated oral solution 20 mg/mL) 5-10 mg PO Q1H:PRN, ***OR***
- Oxycodone (concentrated oral solution 20 mg/mL) 5-10 mg PO Q1H:PRN

Able to swallow, pick one:[1]

- Morphine immediate release tablet 7.5 mg PO Q1H:PRN, ***OR***
- Morphine (oral solution 2 mg/mL) 5-10 mg PO Q1H:PRN, ***OR***
- Oxycodone tablet or liquid 5-10 mg PO Q1H:PRN, ***OR***
- Hydromorphone 2-4 mg PO Q1H:PRN

Increase the dose by 50-100% every hour until efficacy is achieved, then consider adding a scheduled dose every 4 hours.

Intravenous opioid

Pick one:

- Hydromorphone 0.25-0.5 mg IV Q15MIN:PRN respiratory distress, ***OR***
- Morphine sulfate 1-4 mg IV Q15MIN:PRN respiratory distress (avoid in sev. renal failure)

Higher starting doses may be needed for patients coming off high O2 support or a ventilator. If initial dose is ineffective after 2 administrations 15 minutes apart, double the dose. ***Please consult Palliative Care p32502 for assistance.***

[1] These suggestions are not in the POE Comfort Focused Care order set and must be ordered separately.

Opioid infusion

- *For acute symptoms, immediate IV bolus is more effective than opioid infusion.*
- If the patient is intubated in the ICU and already on a fentanyl infusion, and a palliative extubation is now being planned, *do not* change to another opioid infusion.
- Appropriate indications for a new Comfort Care opioid infusion include:
  - Patient has required >24 mg/day of IV morphine equivalents, ***OR***
  - Patient has been requiring daily long-acting oral opioid medications and can no longer tolerate oral route, ***OR***
  - Symptoms not well controlled despite frequent boluses, for instance >1 bolus per hour over 4 hours (alternatively, the bolus dose may need to be increased)
- If the patient is not on an infusion, and one is indicated, pick either:
  - Morphine Infusion – Comfort Care Guidelines (IV DRIP), ***OR***
  - HYDROmorphone Infusion – Comfort Care Guidelines (IV DRIP)
    - Note: use the "quick pick" list in POE, or if searching for "hydromorphone", be sure to scroll *all the way down* to find the Comfort Care infusion order.

Then, in the infusion order, select "Yes" on the prompt to allow boluses. Once the infusion is up and running, remove any other existing PRN bolus order. This will allow the nurse to bolus as needed off the infusion. NOTE: *Infusions require 8 hours to reach a steady state in the absence of bolus dosing*. See BIDMC's Comfort Focused End-of-Life Care Guideline for more information about adjusting opioid infusions.

BENZODIAZAPINES

Can be added to opioids to relieve anxiety associated with dyspnea

- Lorazepam 0.5-2 mg IV/PO Q2H:PRN anxiety

COUGH

- All opioids have central antitussive activity and are first-line treatment for severe cough. There is no evidence that any one opioid is superior to another.
- Utilize opioid dosing as outlined in dyspnea section above.
- If patient able to take PO medications, consider adding:
  - Guaifenesin-Dextromethorphan 5-10 mL Q4H:PRN cough, ***AND/OR***
  - Benzonatate 100 mg PO TID

SECRETIONS

Order non-pharmacologic interventions using the orderset, with emphasis on:

- Try positioning maneuvers to facilitate drainage by gravity.
- Avoid suctioning to lessen the risk of aerosolization, unless the patient is reporting discomfort from secretions.
- Loud respirations ("death rattle") near the end of life are normal and occur in the majority of dying patients. Typically patients are obtunded and unresponsive at this stage. You may need to educate loved ones and staff to lessen observer distress.

Consider pharmacologic interventions:

Pharmacologic (anticholinergic) therapy has limited efficacy and can cause significant side effects including delirium, dry mouth. However, if it is felt to be necessary:

First line:

- Glycopyrrolate 0.1-0.2 mg IV Q4H:PRN excess secretions (quaternary amine structure does not cross blood-brain barrier, so less potential for side effects)

Others, try one of:

- Hyoscyamine 0.125-0.25 mg SL Q4H:PRN excess secretions
- Atropine sulfate 1% 1-2 drops SL Q4H:PRN excess secretions
- Scopolamine patch TD Q72H (not recommended for acute symptoms. Requires 4-12 hours for onset of action and 24 hours to reach peak effect)

OTHER SYMPTOMS: PAIN, ANXIETY, DELIRIUM

Please reference the Comfort Focused Care order set in POE.

OTHER END-OF-LIFE CONSIDERATIONS

- For patients who are somnolent and no longer able to engage with loved ones in a meaningful way, removal of oxygen is an appropriate measure, allows the patient a natural death, and avoids prolonging the dying process.
- If the patient is on a significant amount of oxygen, consider weaning it and treating any symptoms with opioids in a ***stepwise fashion*** before removing the oxygen entirely.
- If planning a palliative extubation, consider pre-treatment with opioids and benzodiazepines to prevent acute symptoms. ***Consult Palliative Care as needed.***

PALLIATIVE CARE CONSULT SERVICE

The Palliative Care Consult Pager p32502 is staffed 24/7. Please do not hesitate to page for any concerns, especially if the patient remains uncomfortable despite initial management.

PSYCHOSOCIAL AND SPIRITUAL CARE

Social Work and Spiritual Care are available to help. Please do not hesitate to reach out to the floor Social Worker, and/or to Spiritual Care p31069.

ADDITIONAL RESOURCES

- CG-28 Guidelines for Interdisciplinary Comfort-Focused End-of-Life Care
- Center to Advance Palliative Care (CAPC): https://www.capc.org/toolkits/covid-19-response-resources/
- Vital Talk: https://www.vitaltalk.org/guides/covid-19-communication-skills/
- Fast Facts from Palliative Care Network of Wisconsin: https://www.mypcnow.org/

REFERENCES

- BIDMC: CG-28 Guidelines for Interdisciplinary Comfort-Focused End-of-Life Care
- Dartmouth Hitchcock Medical Ctr: COVID-19 Symptom Management Quick Reference
- Fast Fact #27 Dyspnea at End-of-Life, April 2015; Palliative Care Network of Wisconsin
- Fast Fact #199 Opioids for Cough, July 2015; Palliative Care Network of Wisconsin
- Fast Fact #200 Non-opioid Antitussives, July 2015; Palliative Care Network of Wisconsin
- Jennings AL, et al. A systematic review of the use of opioids in the management of dyspnoea. Thorax. 2002 Nov;57(11):939-44
- Stanford Health Care: Primary Palliative Care for COVID-19
- Thomas JR and von Guten CF. Clinical management of dyspnoea. Lancet Oncol. 2002 Apr; 3(4):223-8

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