Preparing for Effective Palliation in the face of COVID-19 Pandemic

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No Conflict of Interest

- No sponsorship or financial interest
- We may recommend off-label use of medications

Outline

- Describe goals of care discussions in the face of COVID-19.
- Identify essential tools for symptom management and end of life care of COVID-19 patients.

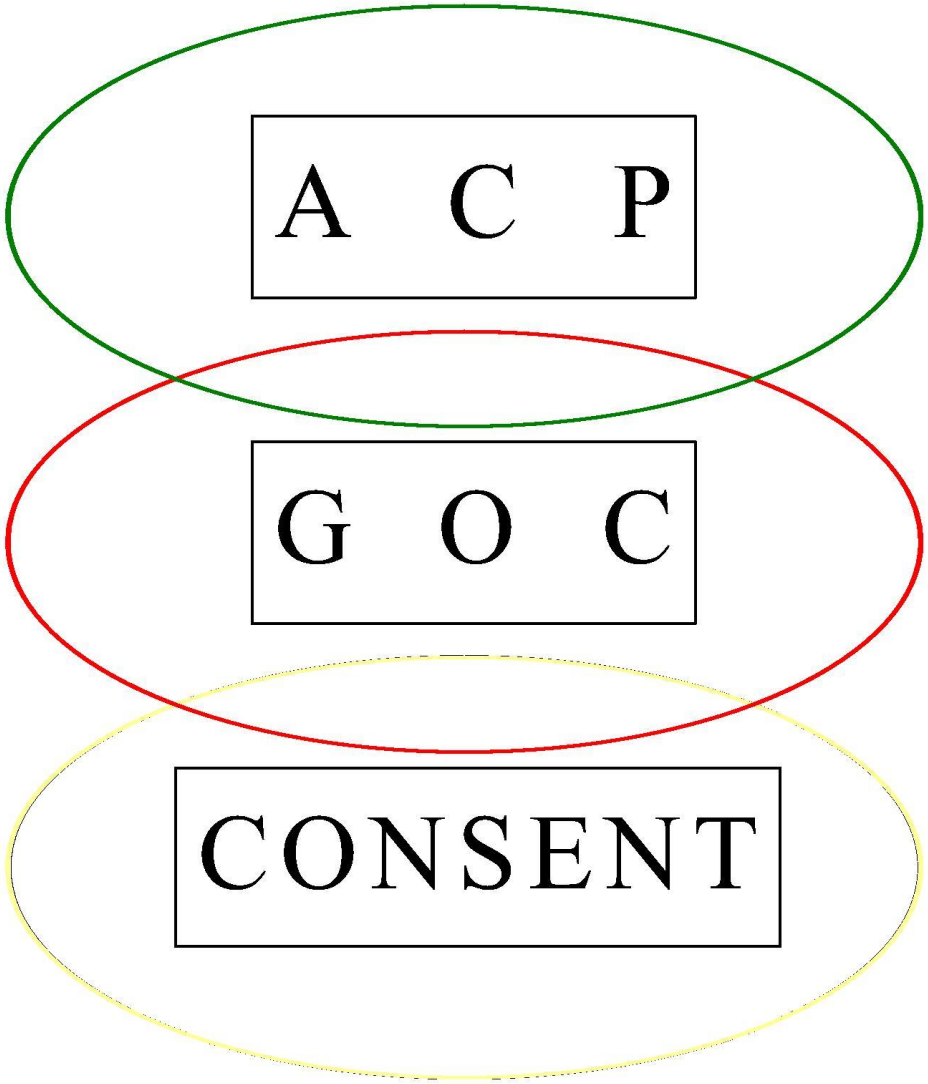
- *The single biggest problem in communication is the illusion that it has taken place.*
  - G. Bernard Shaw (1973)

Early

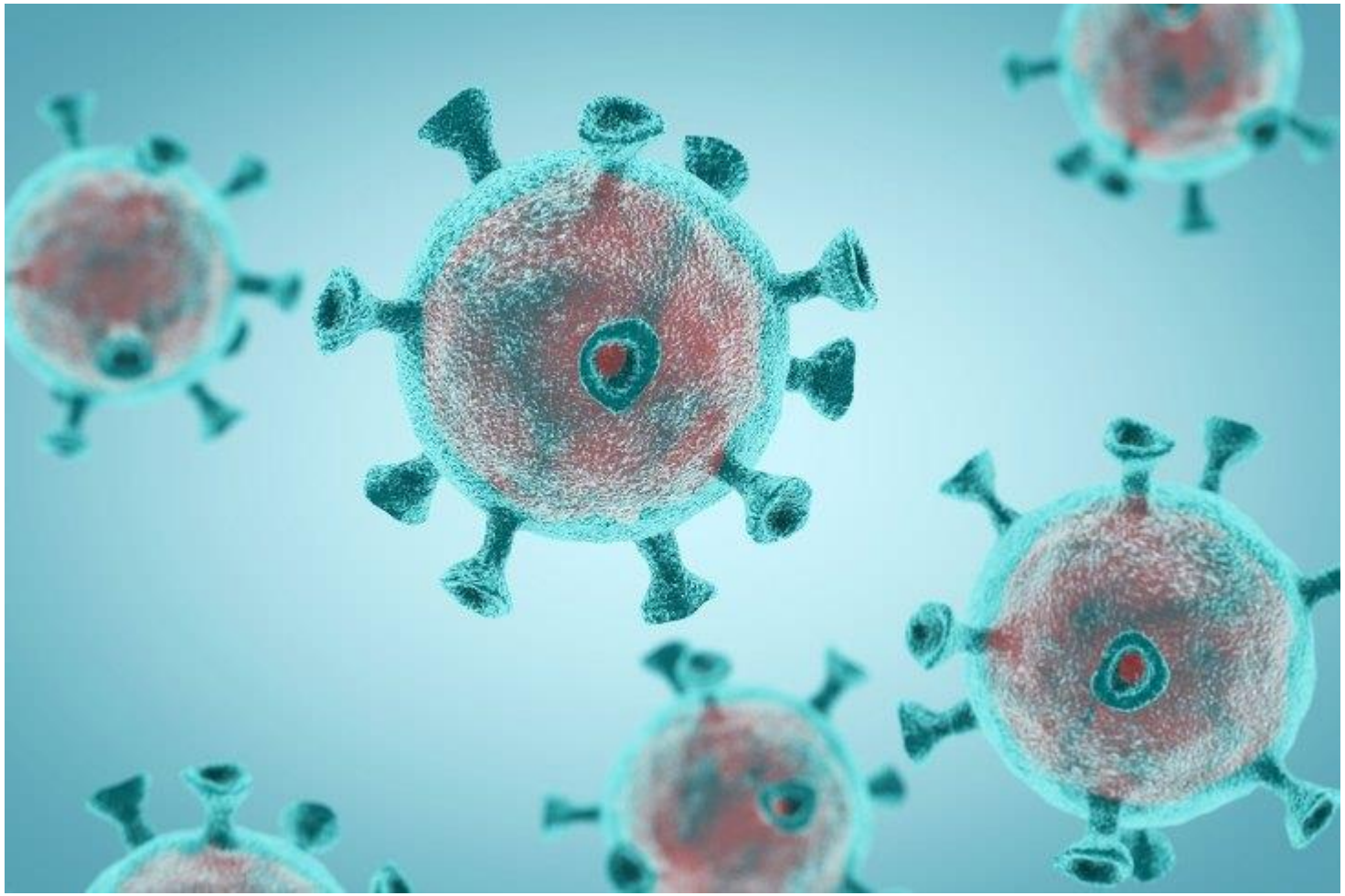
…

Present/ current

Immediate

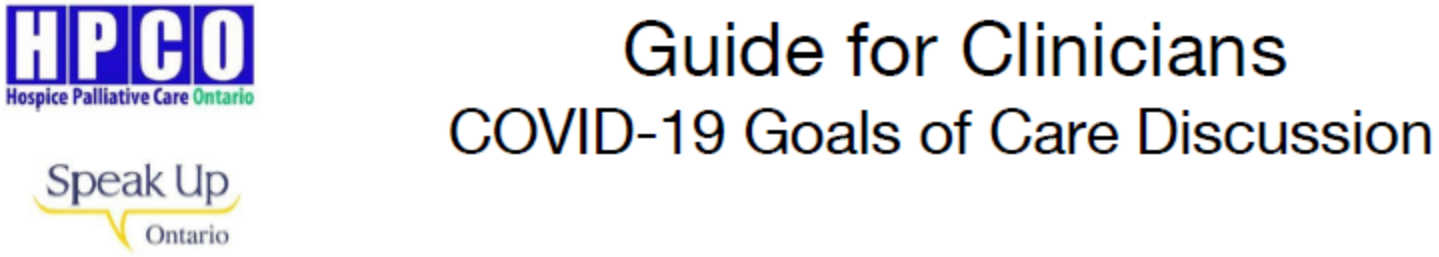


Covid-19



HPCO – Guide for Clinicians
COVID-19 Goals of Care Discussion

- https://www.hpco.ca/advance-care-planning-health-care-consent-goals-of-care/



GOC - Communication

1. Prepare – clinician; medical and prognostic
2. Introduce the conversation – Patient and SDM
3. Explore understanding - Patient and SDM
4. Sharing Information – ensure same page
5. Values and Goals – what is important?
6. COVID – information sharing
7. Recommendations and summarize a plan

Step 1: Prepare

Gather relevant information

- Know person's current clinical condition and ensure SDM is present in-person or virtually

Mr. Bevin Kazanson - 74 years, married, 2 adult children- Wife of 49 years is his SDM;
Medical History: Diabetes Mellitus, CAD, with ischemic cardiomyopathy and reduced EF (est 35%), COPD (FEV1 39% predicted).
Lives at home, support with wife, ambulates with walker. 2 falls in past 3 m; required EMS to get him up, but refused hospital transfer.

Case Review - 2

- Mr. Kazanson's family called your office. He has been feeling worse and is having difficulty getting out of his lazy boy.
- Family feel he should go to hospital, but he is resistant.
- Hospital is not presently in surge, and there is likely capacity for usual medical care.*

2. Introduce the conversation

Step 2: Introduce the conversation Outline what will be discussed and gauge level of anxiety or worry	
There is a lot of fear and uncertainty now. The situation in Ontario is changing quickly and we don't yet know the extent of what to expect. *Because of this, we are talking with as many people as possible who have (or have family who have) serious illness or who are at risk of becoming very sick if they were to become infected with coronavirus.* *This is not to scare you, but to help you and your family be as prepared as possible. One way to prepare is to learn more about who you are and what's important to you as you think about the future.*	*What do you know about the situation with coronavirus and why our conversation today is important?* *In the past, have you discussed with anyone your wishes about care in the future? This is called advance care planning.*

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Speak Up Ontario

3. Explore Understanding

Step 3: Explore understanding of underlying illness and COVID-19

Identify information requiring clarification e.g. serious illness being incurable or progressive in nature

What do you understand about your current health? What do you expect to happen over time?

E.g. Do you expect to get better, be cured, or is your illness expected to get worse over time?

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4. Share information

Step 4: Give information about underlying illness

Ensure accurate understanding of the expected illness course and where the person is in their illness trajectory

- Give information about underlying serious illness
- Expect emotion and respond with empathic statements
- Give short amounts of information
- Pause and check understanding

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5. Explore Values and Goals

Step 5: Explore values & goals

If NOT in surge protocol, identify values & goals that can be translated into wishes about care escalation.
It is important to understand baseline values, goals & wishes before discussing COVID-19.
If in surge protocol, skip to Step 6.

As you think about your future and your health, what comes to mind as being important?
E.g. being able to live independently, being able to recognize important people in your life, being able to communicate, being able to enjoy food, spending time with friends & family etc.

Think about the care you might need if you have a critical illness. What worries or fears come to mind?

(For people in institutional settings) *How do you feel about being transferred to hospital? And, why?*

Think about your life in the future. Describe the states that are acceptable and unacceptable for you.

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6. Give Information re COVID-19

Step 6: Give information about COVID-19

For a person in an institutional setting, sensitively inform them about the possible scenario that transferring to hospital may not be possible. ***For a person at home,*** sensitively prepare them for what might happen if they become so sick, they are considering going into the hospital. The overall message is one of being hopeful that all treatments and care will be available but preparing in the event they are not.

I'd like to talk about the effect of coronavirus on people who have other medical problems. It is difficult to talk about this, but many people prefer to have information so they can feel prepared. Is it ok to share this info with you now?

We know most people who get coronavirus will recover or might need some temporary treatments. Unfortunately, there is no cure for coronavirus, which is a worry for people with serious illness like heart or kidney disease or frailty.

People with other medical problems who get coronavirus have a much harder time recovering. These are the people who we worry most about dying from coronavirus. The reason is that their body is already dealing with illness and adding a viral infection means they might not have the reserve to fight the infection.

I don't expect this to happen to you, but I wouldn't be doing my job if I didn't bring this up with you.

(Pause for possible questions or emotions)

I also need tell you a bit about what might change in the health care system because of coronavirus.

In ordinary circumstances, people who become very sick have access to treatments like CPR and life support as well as the critical care unit. Unfortunately, if coronavirus gets very bad in Ontario, there will be changes to the health care system and the resources that are available.

The best evidence tells us that among people who are so sick they need critical care, the people who recover have no other health conditions and before becoming sick they are living at home, independently. The best evidence also tells us that for people who have serious illness if CPR or life support is needed it is very unlikely, they will survive. This is why if seriously ill people become even sicker, CPR, life support and critical care may not be offered.

I wish it were different but if coronavirus gets very bad in Ontario, I'm worried some of what we've talked about today might not be possible for you. I hope this won't happen, but we can be prepared if it does.

Many people I've spoken with are most worried about what it would feel like if they are dying and worry, they will suffocate and suffer. I want you to know that if you got very sick, we will be able to help you, to keep you comfortable with some very good medicines.

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7. Recommend & Document Plan

Step 7: Recommend & Document a plan

Agree on what was discussed, ensure understanding of recommendations & outline next steps

- Summarize key details of the discussion

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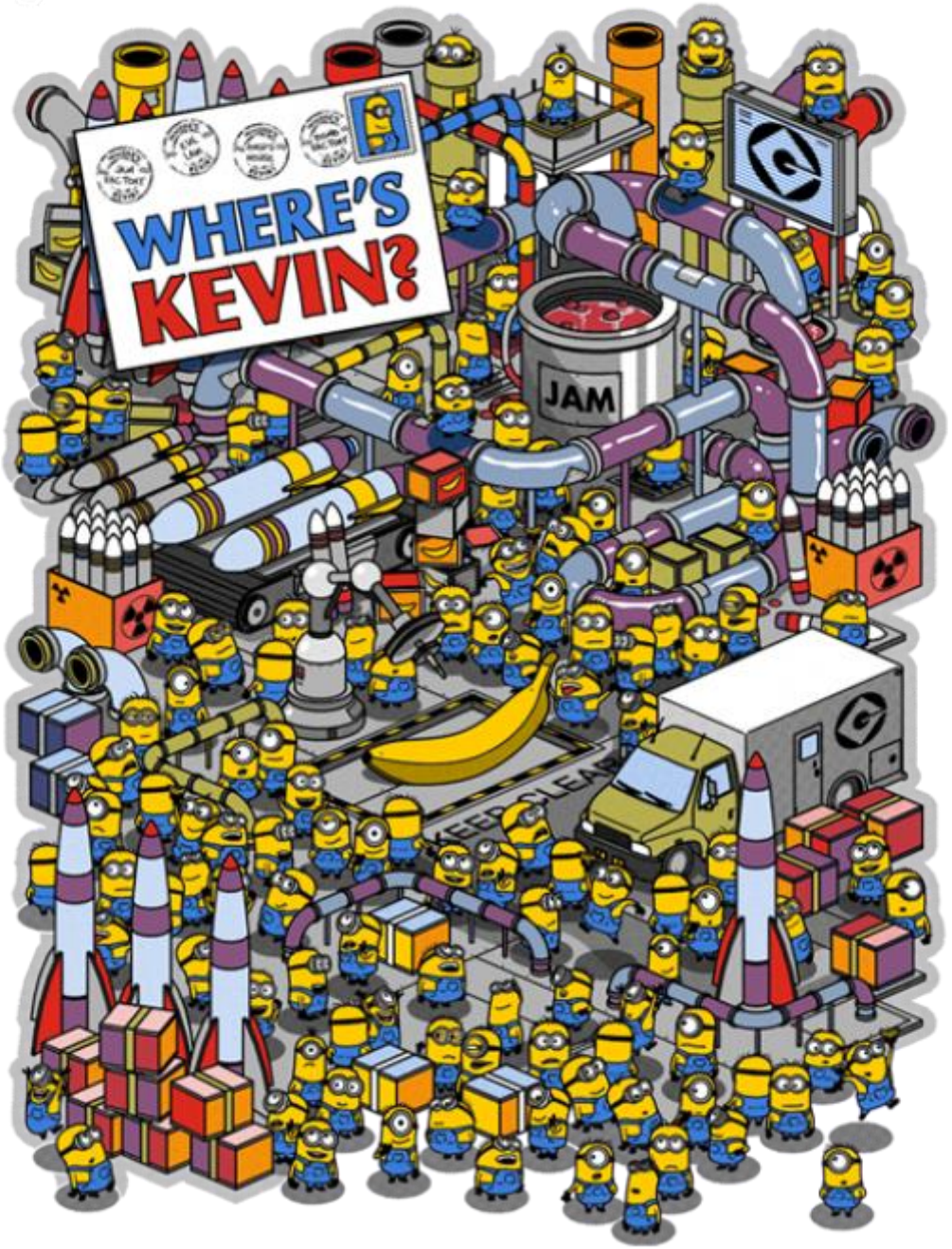
Ontario

Resources /References

- HPCO - https://www.hpco.ca/advance-care-planning-health-care-consent-goals-of-care/
- PALLIUM - https://www.pallium.ca/course/covid-19-response-free-online-modules/
- https://www.youtube.com/watch?v=Oh1SVOQUn08&feature=youtu.be
- Buckman, R. Breaking Bad News (Spikes)
- https://www.vitaltalk.org/



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)
- Oral or airway suctioning (especially deep 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.
Version: April 9, 2020

Ontario Palliative Care Network

Ontario Health

https://www.ontariopalliativecarenetwork.ca/sites/opcn/files/EndOfLifeSymptomManagement-COVID19.pdf

Start from the very beginning…

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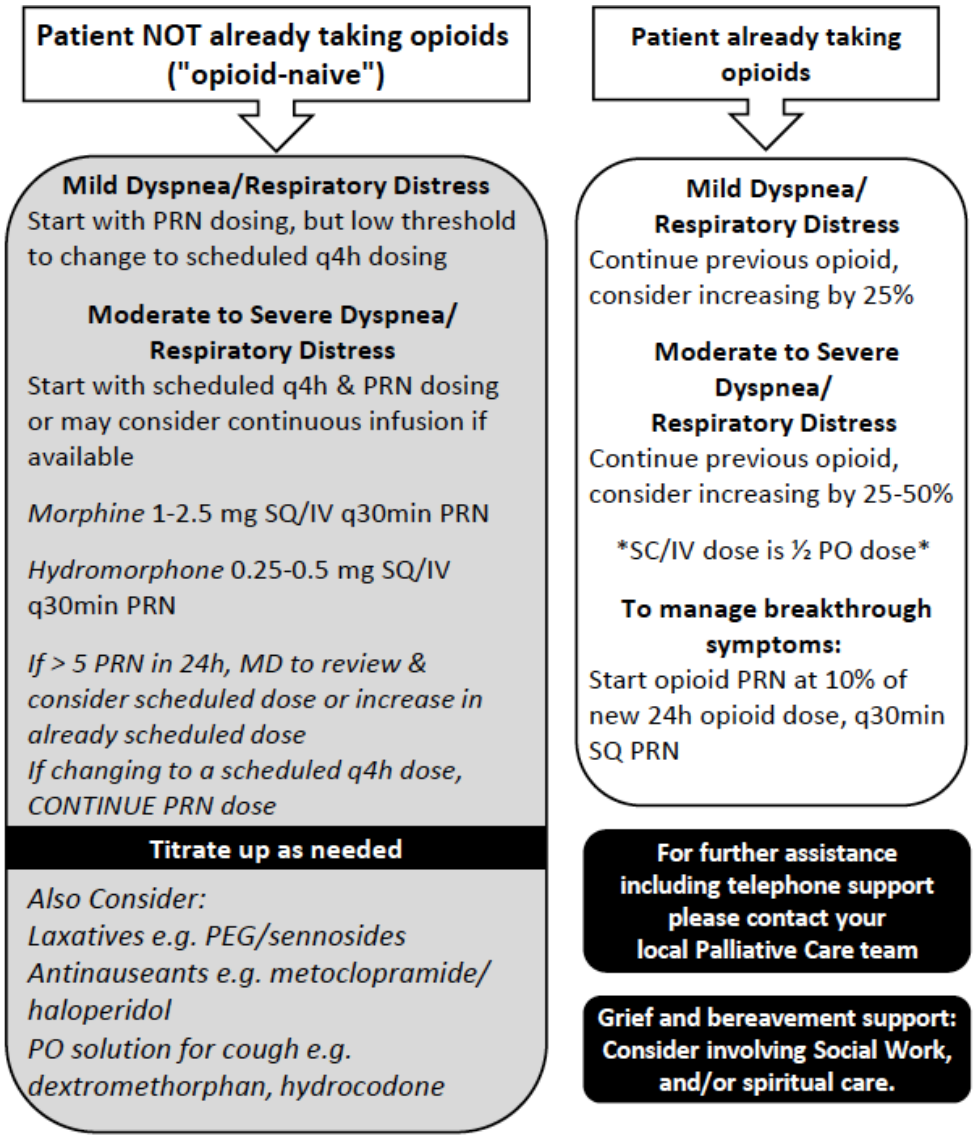
All below are STARTING doses. COVID-19 symptoms may advance quickly. Be prepared to escalate dosing.
Consider dose ranges to give frontline staff capacity for urgent clinical decision-making as needed.

- GOC comes first, but good symptom management is part of ALL care for COVID;
- Emerging clinical experience - condition can change VERY rapidly and sometimes requires dramatic dose escalation!

Opiates backbone of dyspnea management



Combinations often needed for more severe symptoms

For All Patients:
Adjuvant Medications

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Methotrimeprazine 2.5-12.5 mg SQ/IV q2h
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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.

- Lorazepam or Midazolam can be given Subcut / IV
- Methotrimeprazine (Nozinan) is more sedating and often preferred in more palliative approach to care
- Continuous sedation is for refractory symptoms, but could be more challenging given medication availability

Secretion Management

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

- Snoring analogy
- Glycopyrolate / Atropine less sedating vs. Scopolamine more sedating

Aersolization

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)
- Oral or airway suctioning (especially deep suctioning)
- Bronchscopy and tracheostomy

- If needed must use appropriate PPE (Respiratory vs. Droplet)

Essential Care Partners

Non-COVID End of Life

- Max 4 visitors, 2 at a time, if significant risk of death in 24hrs
- 1 visitor if less than 72 hours

COVID or COVID Suspect (changed Apr 24)

- Max 2 essential care partners, 1 at a time, escorted in PPE

The health and safety of all staff, professional staff, patients and the community is our utmost priority. To protect the community, we restricted all essential care partners from visiting patients in COVID-19 care areas under any circumstance. However, that does not align with our Patient & Family Centred Care philosophy. A team revisited the restriction to develop guidelines that allow visits under exceptional palliative care circumstances. This applies to patients infected with the COVID-19 virus in any area, including the dedicated COVID-19 Care Unit and Intensive Care Unit. The guidelines include the use of Personal Protective Equipment (PPE) for the ECP, as well as other specific measures that ensure the safety of family and staff.

Curated COVID Palliative Care Resources

Ontario Palliative Care Network (OPCN)

https://www.ontariopalliativecarenetwork.ca/sites/opcn/files/PalliativeCareResourcesForFrontlineProviders-COVID19.pdf

Text Based Symptom Management (3 pager)

https://www.nosm.ca/wp-content/uploads/2020/04/COVID-19-END-OF-LIFE-SUPPORTIVE-CARE-SYMPTOM-MANAGEMENT-Guidelines-March-2020.pdf