McMaster University PALLIATIVE CARE:
Protocols for Symptom MANAGEMENT OF PATIENTS WITH COVID-19

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SYMPTOM	TREATMENT
Dyspnea	See separate Dyspnea management algorithm
Upper Airway Secretions	• Advise family and bedside staff: not known to be uncomfortable, just noisy (like snoring) • If mild, no drugs needed. No suctioning. May reposition. • If moderate to severe, no suctioning. Start pharmacological treatment: **Scopolamine**: 0.4-0.6mg subcut q 4hrs PRN (more sedating than glycopyrrolate, which may be useful if patient is also agitated) **OR** **Glycopyrrolate**: 0.4mg subcut q 4hrs PRN Timely management is important when the secretions start worsening. Select according to availability of medications. (If ARDS/pulmonary edema related lower airway secretions, administer furosemide 20mg - 40 subcut/IV q2hrs PRN and monitor
Cough	• If on opioids already, titrate (see Dyspnea protocol) • If not on opioids: ○ If moderate, select one of the following: ▪ Dextromethorphan 10mg-20mg PO q 4-6 hrs PRN ▪ Hydrocodone 5mg q 4-6hrs PRN ▪ Normethadone antitussive (Cophylac) 15 drops po QHS or BID (Not ODB covered, on backorder as of 30March2020) ○ If severe: Start opioid ▪ Morphine 2.5 - 5 mg PO q4hrs (SC dose is ½ of oral dose) Or ▪ Hydromorphone 0.5 - 1 mg PO Q4H (SC dose is ½ of oral dose) ▪ For any opioid, reduce the dose by half and consider q6hrly dosing if patient is frail, elderly or has advanced comorbid illness. ▪ If moderate to severe renal impairment, use hydromorphone instead of morphine.

Fever	• **Acetaminophen** 650mg PO or PR q 4 h PRN
Delirium & Agitation	• 1st line: **Haloperidol** 0.5mg to 1mg subcut/IV q 4 hrs PRN If 4 or more PRNs in 24 hrs, provide regular dosing schedule of q 4h or q6 h, or consider 2nd line* • 2nd line: **Methotrimeprazine** 6.25mg to 12.5mg subcut q 4 hrs PRN OR **Midazolam** 1mg to 2mg subcut/IV q 1hr PRN (may be higher if severe agitation)
Nausea & Vomiting	Options: • **Metoclopramide** 5mg -10mg subcut q4hrs PRN (PO if not severe) • **Ondansetron** 4mg - 8mg subcut/IV TID PRN (PO if not severe) • **Haloperidol** 0.5mg - 1mg PO or subcut q4hrs* PRN (PO if not severe)*
Pain	• Mild: Acetaminophen • Moderate: weak opioid (see https://palliativeezguide.ca/ for guidelines) • Severe: regular opioid plus PRN (see https://palliativeezguide.ca/ for guidelines)
Anxiety	• **Lorazepam** 0.5mg to 1mg PO or SL q2hrs PRN. (SL not covered in community) • **Clonazepam** 0.25mg to 0.5mg po q8hrs PRN (longer acting)
Dry Mouth	• Mouth care with mouth swabs QID and PRN • Artificial saliva if available (sprays, gels)
Intractable Symptom	See separate Palliative Sedation Guidelines and Protocol (specific for COVID19)
*Haloperidol can be useful for delirium and nausea. Use this medication if a patient experience both problems simultaneously. Also avoid giving two different anti-dopamine agents at the same time to reduce the risk of extrapyramidal side effects.	

Palliative Care Pain and Symptom Management Guide, Division of Palliative Care

Free downloadable guide with protocols on pain and symptom management developed by Dr Nadia Plach and members of the Division of Palliative Care, Department of Family Medicine, McMaster University. These guidelines are for palliative care in general.

https://palliativeezguide.ca/

Limited use (LU) Codes for home/community prescriptions

- Use LU481 for:
  - morphine injectable 10mg/ml or 2mg/l, scopolamine, glycopyrrolate
- Use LU495 for: Midazolam 5mg/ml,

Suggested language for physicians providing support to a patient or family member who is denied intensive care due to resource scarcity

(Courtesy of Champlain Regional Palliative Care Program)

Normally, when somebody develops critical illness, the medical team would offer them intensive care (a combination of medications and machines to support their vital organs), provided that the medical team felt that they had a reasonable chance of survival. However, because of the COVID outbreak, we are currently unable to offer intensive care to everyone who is critically ill. As a result, our hospital is working under triage guidelines, which means that we are only offering intensive care to those who are most likely to be able to survive and recover from their critical illness. You probably have heard about this in the news – all hospitals in the region are working under these guidelines.

I regret to inform you that we are unable to offer you intensive care treatments at this time, as a result of the triage guidelines. Because of your medical condition, the likelihood that you would survive even with intensive care is considered to be too low for us to offer intensive care. The team has made this decision based on the following information:_____.

I am deeply sorry about this situation. This is not the way we ordinarily make these decisions, and I can only imagine how you must feel right now. I want you to know that even though we cannot offer intensive care, we will do everything else that could conceivably give you a chance of recovering, including: _____.

And I promise you that, no matter what, we will also use medication to treat any discomfort, such as pain or shortness of breath. We know that when we treat discomfort appropriately, this is not harmful and may actually help improve your condition.