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Modifications to Palliative Care Symptoms Management in COVID-19 Positive Patients

BREATHLESSNESS		
	"Usual" Palliative Care	**Palliative care for COVID-19 +ve patient**
Fans	Fans are sometimes recommended as a useful non-pharmacological approach	Fans are not to be used as they aerosolize the virus
High flow oxygen* *"High flow": Definitions of this vary; e.g. ≥ 60% O2, or as per CAEP > 6lpm	Oxygen is suggested when a patient is hypoxic and experiencing dyspnea. In some cases, high flow oxygen may be required, titrated to clinical effect.	High flow O2 aerosolizes virus. If needed, PPE will be needed to care for the patient (or in the pt's area)
Non-invasive ventilation	BiPaP or CPAP is used in select cases; eg. End-stage ALS or COPD	Non-invasive ventilation may be helpful in select patients who are seriously ill with COVID-19 and ventilators are not available (or avoid intubation and ventilatory support). However, PPE has to be used in these cases
Airway secretion management	Secretions are usually from the upper airway. In severe cases, scopolamine or glycopyrrolate PRN is recommended.	In severe COVID-19 disease, ARDS and pulmonary edema is more common. The treatment is thus more geared towards using furosemide and ARDS approaches if the secretions are from the lower respiratory tract
Opioid **Note:** *Morphine remains a useful first-line opioid, even though some suggest hydromorphone. Hydromorphone is preferred if a patient has moderate renal impairment. Fentanyl is preferred in severe renal impairment and failure (but ask palliative care service for advise*	Opioids are useful in the management of severe dyspnea. They are safe and effective (see LEAP online module on Dyspnea for guidelines on doses).	Opioids are very useful in the management of severe dyspnea. They are safe and effective (see LEAP online module on Dyspnea for guidelines on doses). With COVID-19, they may need to be initiated even sooner for their physiological and symptom-relief benefits

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PALLIATIVE SEDATION		
IMPORTANT: Palliative sedation should only be considered for patients with intractable symptoms. Continuous palliative sedation does not include temporary sedation (for a few days) where treatments are being administered with an expectation that the person will recover	Most guidelines suggest methotrimeprazine or midazolam continuous infusion as first choice drugs. Phenobarbital is considered second or third line, added to midazolam if midazolam alone is ineffective.	In the pandemic, if shortages of midazolam occur, methotrimeprazine becomes a first choice. If infusion pumps are not available, may have to use intermittent injections of midazolam (or methotrimeprazine). If methotrimeprazine or midazolam are not available, may have to use phenobarbital or lorazepam as first choice. Different options should therefore be available
EMERGENCY KITS		
	In usual palliative care, some experts recommend the routine use of emergency kits in the home to ensure patients have access to key medications in the last days and hours in case of a crisis, to ensure comfort and avoid ED transfers. These are generic kits with medications such as opioids, haloperidol, methotrimeprazine, scopolamine (types of meds vary from region to region). Once these are dispensed, the medications cannot be reused by anyone else and have to be disposed of, resulting in some wastage. Prompting some experts to recommend instead a just-in-time, tailored-to-specific-patient approach; with kits tailored to medications the patients needs at a specific time and when they need it – this requires a system in place with 24/7 access to pharmacy services which are sometimes not available in rural regions or small communities.	In the pandemic, there is a great risk of significant wastage of precious medications such as midazolam if generic kits are prescribed to all patients in anticipation of possibly developing a problem. Implement measures and processes to reduce wastage
GOALS OF CARE		
	In usual palliative care, autonomy remains a core principle in goals of care conversations, which allows patients to choose the location of death as well as life-sustaining measures.	In a pandemic, autonomy may be compromised. • E.g. options for location of death may become limited. LTC and hospices may need to limit admissions. • Care at home may be limited if family are not able to safely participate in the care. • Transportation systems could be disrupted, not allowing for

		patients to be moved to different locations of care. • Sequestered units may provide economies of scale • In a situation of resource scarcity, some patients may not be able to be offered intubation and ventilation.
PSYCHOSOCIAL SUPPORT		
	In usual palliative care, providing support to family caregivers via an interprofessional team is a core part of the work. Providing psychosocial support to patients involves treating depression, anxiety, hopelessness, and existential distress.	• In a pandemic, families may not able to visit due to facility specific restrictions as well as travel restrictions. • Families may not be able to provide care in the home • Patients may be feel stigmatized if health care professionals avoid physical examination and sitting down at the bedside. • Communication (due to masks) may be more difficult if patients have hearing, orvisual impairments, or delirium.
GRIEF AND BEREAVEMENT		
	In usual palliative care, patient's loved ones are supported during the grieving process. They are allowed to be at the bedside and health care providers often meet with them. Spiritual care providers can support with desired rituals. Funeral arrangements allow for all family members and loved ones to be present.	In a pandemic, families may suffer complicated grief if they cannot see their loved ones. Spiritual care services may not be able to be offered. Funerals may be limited to immediate family only. Loved ones may not be able to touch the body.