

End-of-life care for the patient dying of COVID19 in the Emergency Department

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Remember

- You won't be able to save everyone.
- You are a caring clinician, and your small acts of kindness are meaningful.
- You already have palliative care skills.

Objectives

- Communication
- Goals of Care conversations in the ED
- Symptom management
- Available palliative care resources

Communication

- “I’d like to talk with you about how to best care for you with this illness. Is that okay?”
- “What is your understanding of what is happening to you?”
- “May I tell you what I think is happening?”
- Leave silence
- “Have you already thought about what’s most important to you in this situation?”
- “I’d like to make a recommendation”

R

“If we think there is a reasonable chance that you will survive COVID19 using all available treatments including a breathing machine, then are you willing to try those things?

We call this Resuscitative Care. “

M

”I’m worried that if you get sicker, using a ventilator is unlikely to help you survive and get back to a quality of life that is important to you.

I want you to know that we will do all we can to support you using aggressive medical treatments (like oxygen and IV fluids) and also ensuring you are comfortable.

We call this Medical Care”

C

“I want you to know we will keep taking care of you the best we can. I’m hoping you won’t get worse, and we will always make sure you are comfortable, for as long as you are with us.

We will focus entirely on your comfort and allowing a natural death when it comes. We won’t be focusing on life prolonging measures.

We call this Comfort Care.

AVOID SAYING:

"A *patient* in this stage of covid..."

"There is nothing more we can do"

"Choose from the options on this goals of care sheet"

"Don't worry, you'll die quietly and peacefully with these drugs"

"You must be strong for your family"

"We are withdrawing care"

"We should *step down* to comfort care"

"Doing CPR will break your ribs"

"Would you like us to do everything?"

RECOMMEND SAYING:

“I will do my best to look after you”

“I hear your worry/fear (name emotion).
Would you like to tell me more about how
you are feeling?”

“We will not abandon you. We will always
keep trying to make you comfortable”

“I’m so sorry your loved one cannot visit.
You are not alone, we are here. I will call
your family and update them”

“Hello, I’m Dr. Hughes, the emergency
physician. I’m so sorry we cannot meet in
person.”

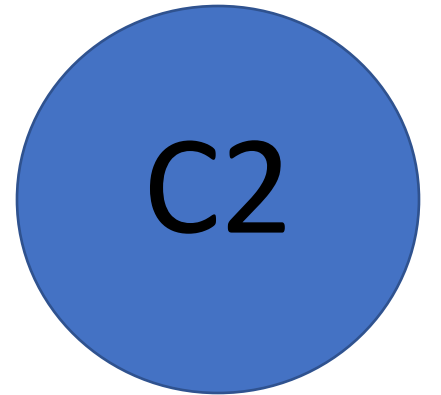
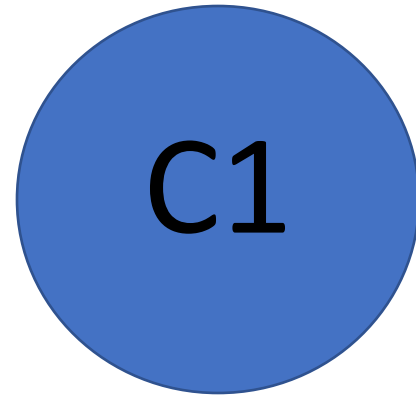
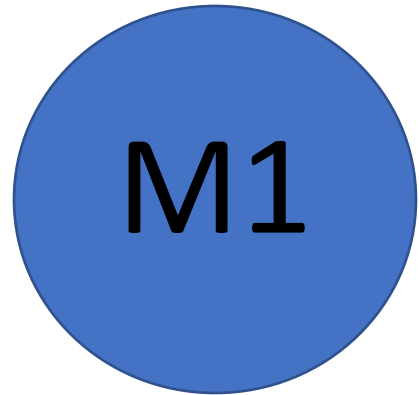
I wish it wasn’t so, and I’m sorry to have to tell
you this”

”I wish I could change what was happening”

“A ventilator will not help your loved one/is no
longer helping, but we won’t stop caring for ...”

”Although we have no way to prolong her life,
we will keep working to ensure she does not
suffer and is comfortable.”

Symptom management for adults with COVID-19 receiving EOL care



Dyspnea

- Opioids
 - Do not hasten death
 - Do not cause respiratory depression
- Lower doses compared to analgesic dosing

Dyspnea – things to avoid

- Avoid
 - Deep suctioning
 - Fans
 - Humidified/ high-flow oxygen
 - NIV
 - Nebulized treatments
 - Extubation*

*If changing to C1/C2 GCD in ED, consider not extubating, but weaning ventilator while providing comfort care

Dyspnea management

- Hydromorphone
 - 0.25-0.5 mg iv/sc or 0.5-1.0 mg po q1h prn
- Morphine (avoid in renal failure)
 - 1.25-2.5 mg iv/sc q1h prn or 2.5-5 mg po q1h prn
- Titrate to effect
- If > 4 doses needed in 24 hours, consider ATC dosing q4h (q6h in frail elderly or GFR < 30)

Refractory Dyspnea

- Midazolam 2-5 mg sc/iv q 30 min prn
- Ketamine 1-2 mg/kg IV as a rescue
- Strongly consider palliative care consultation
- Consider palliative sedation*

Agitation/Delirium

- Decide if a work-up is indicated.
- Correction of underlying etiology can still be good symptom management.

- Haldol 1-2.5 mg iv/sc/po q8h and q1h prn

- Methotrimeprazine 12.5 mg po/sc/iv q8h and q1-2 h prn

Refractory agitated delirium

- Midazolam 2-5 mg IV push q30 minutes prn
- Strongly consider palliative care consultation
- Palliative sedation*

Respiratory secretions at EOL “Death rattle”

1. Weakness, inability to clear secretions, upper airway

- Noisy but patient usually not uncomfortable.
- Final hours to short days.

2. Bronchial secretions

- More difficult to treat.

- Glycopyrrolate 0.4 mg sc q4h prn
- Or: Scopolamine 0.4 mg sc q4h prn
- Or: Atropine 1% ophthalmic drops SL q4h prn

Pain

- Opioid Naïve:
 - Morphine 2.5-5 mg IV/SC q1h prn or 5-10 mg po q1h prn
 - Hydromorphone 0.5-1 mg IV/SC q1h prn or 1-2 mg po q1h prn
 - Low threshold to schedule it around the clock q4h or q6h
 - PO : IV/SC 2:1

Pain

- Opioid Tolerant

- Increase previous opioid total daily dose by 25%
- OR Calculate new dose
 - Add up total dose in 24 hours (breakthrough + ATC)
 - Divide into q4h or q6h doses
 - New breakthrough dose 10% of total daily dose q1h prn

HM CR 12 mg po bid
+ HM 2 mg q1h prn x
6 doses

= HM 24 mg + 12 mg
= HM 36 mg po / 24
HOURS

NEW DOSE =

HM 6 mg po q4h +
+ HM 4 mg po q1h
prn

Nausea/Vomiting

- Metoclopramide
 - 5-10 mg IV/SC/PO q4h prn
- Haloperidol
 - 1 mg IV/PO/SC q4h prn
- Ondansetron
 - 4-8 mg IV/SC/PO q8h prn

Palliative Sedation

- The use of sedation to treat REFRACTORY / INTOLERABLE symptoms in final **HOURS** to **DAYS** of life.
- Consider when all other appropriate interventions have failed, or there isn't time for them to work.
- NOT equivalent to MAID.

Criteria

- Progressive incurable condition causing severe suffering in final hours to short days of life.
- Refractory symptoms:
 - All reasonable options have been tried
 - Alternatives would not be effective in time
 - Burdens/side effects of alternatives not acceptable
- C2 goals of care
- Documented consent of patient +/- SDM
- Strongly consider palliative care consult

Language for patients and families

- “Palliative sedation involves using medications to put the patient into a deep sleep when suffering cannot be managed any other way, until natural death occurs.”
- “There is no clear evidence that it shortens life; it is not the same as MAID.”
- “The goal is not to shorten the road, but smooth the bumps in the road”
- “We consider this only when suffering is not relieved for someone who has already started the dying process.”
- “Once we provide palliative sedation, the patient will not be able to communicate, and they will not wake up again. “

Medications

- Midazolam bolus and infusion IV/SC
 - Bolus 2.5-5mg IV/SC
 - Infusion 1-10 mg / hour.
 - Titrate to RASS -4 or -5
 - Bolus doses 2.5-5 mg IV/SC q 10 minutes prn to achieve RASS goal.
 - Every time you give bolus, increase the infusion by 1 mg/hour.

**watch for paradoxical agitation

Medications for Palliative Sedation

- Methotrimeprazine
 - Can use in place of or in addition to midazolam
 - 12.5-25 mg sc/iv q 6h and 12.5-25 mg q1h prn
 - Max 300 mg/24 hours

** watch for paradoxical agitation, EPS

** lowers seizure threshold

Phenobarbital

- Can use in place of midazolam or in addition to
- Very long half life (50-120 hours)
- 1-3 mg/kg bolus
- 30-120 mg IV/SC q 8-12h
- Good starting point 60 mg q 12 hours
- Max 720 mg/24 hours

General End-of-Life Care

- O2 for comfort and consider weaning it
- D/C vital signs
- D/C monitors
- D/C all medications not contributing to comfort
- D/C IV fluids
- Consult social work: use videoconferencing for patients/families
- Acetaminophen 650 mg PR q4h prn for fever causing discomfort
- Eye and mouth care (C2 order set in SCM)

Care after death

- Present family can stay 30-60 min after death
- No additional visitors may come
- Unlikely religious / cultural practices
- Safe handling / limited contact with body
- COVID 19 alone is not a notifiable death to ME

Palliative Care Consultation Service in CZ

- Consult via SCM in Calgary Acute Care sites or RAAPID if not in hospital.
- Site specific physician during the day.
- City-wide physician on call at night and on weekends.
- Predominantly consultative service.
- Admission should go through regular pathway.
- Consult us if: first line treatment not working, complex goals of care conversations.

Summary

- You have the tools to skillfully provide end of life care.
- It is as important as providing critical care.
- Practice your rapid goals of care conversations. Have language ready.
- Treat dyspnea with low(er) dose opioids.
- Treat agitated delirium with neuroleptics.
- If that fails, consider consulting palliative care and commencing palliative sedation (midazolam first line).

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