About This Guide

Palliative Care Skills for all Clinicians

The COVID-19 pandemic presents a severe acute care crisis of unknown duration, in which potentially thousands of people may get sick impacting patients, families and clinicians. In this moment, the priorities of palliative care — quality of life, discernment of patient goals, pain and symptom management, and support for caregivers — have never been more crucial.

We’ve compiled this toolkit to help clinicians in our community respond to the epidemic. The volume of serious ill patients may exceed the capacity of palliative care clinicians in our Network, so these guidelines are intended to provide an extra layer of support to any clinician managing serious illnesses caused by the COVID-19 pandemic.

This Toolkit Contains:

• Communication guidance specifically for the COVID-19 crisis

• Crisis symptom management protocols

• Information on how Palliative Care can support you and your patients

What Next?

As the pandemic evolves, we may issue updated guidelines to respond to the situation. If you have non-urgent questions about the toolkit, please reach out to talkvermont@med.uvm.edu. For everything else, please call or page our Palliative Care teams.

We are being called to action at a moment of unprecedented need. Together, we’ll get through the weeks ahead by summoning our compassion and expertise in service of the communities we serve.
Contents

Section 1: Communication Skills
• COVID-Related Conversations Guide
• Tips for Telemedicine Communication

Section 2: Symptom Management
• Fever
• Dyspnea
• Pain
• Cough
• Secretions
• Nausea/Vomiting
• Agitation/Delirium
• Care for Actively Dying Patients

Section 3: When to Call Palliative Care
• Specialist Palliative Care for COVID-19
• Contact Numbers

Section 4: Appendix
• General Opioid Information
• Empathetic Continuers
• More COVID-19 Related Conversations Tips
• References
COVID-Related Conversation Guide & Communication Tips
Conversations | Screening and Preferencing

VitalTalk, a nonprofit organization dedicated to improving communication skills for serious illness, has crowdsourced this quick guide to provide practical advice for challenging conversations related to COVID-19. Building on experience in studying and teaching communication, they’ve drawn on their national faculty to create this guide. We have adapted it for our own network.

The appendix has an additional mnemonic to for responding to emotions and more COVID-19 Communication tips.

For general tools for serious illness conversations, go to our TalkVermont resource to download the patient and clinician guides.

### When someone is worried they might be infected

<table>
<thead>
<tr>
<th>What They Say</th>
<th>What You Could Say</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why aren’t they testing everybody?</td>
<td>Currently in our state, we don’t have enough test kits. I wish it were different.</td>
</tr>
<tr>
<td>Why do the tests take so long?</td>
<td>It can be hard to wait. The lab is doing them as fast as they can.</td>
</tr>
</tbody>
</table>

### When someone may want to opt out of hospitalization

<table>
<thead>
<tr>
<th>What They Say</th>
<th>What You Could Say</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am worried about this new virus.</td>
<td>You are right to be concerned. Here’s what you can do: Please limit your contact with others. Then you should pick a person who knows you well enough to talk to doctors for you if you did get really sick. That person is your health care agent.</td>
</tr>
<tr>
<td>What should I be doing?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If you are the kind of person who would say, no thanks, I don’t want to go to the hospital if I were to get very sick, you should tell us and your health care agent.</td>
</tr>
<tr>
<td>I realize that I’m not doing well medically even without this new virus.</td>
<td>Thank you for telling me that. What I am hearing is that you would rather not go to the hospital if we suspected that you have the virus. Did I get that right?</td>
</tr>
<tr>
<td>I want to take my chances at home / in this long term care facility.</td>
<td></td>
</tr>
</tbody>
</table>
## Conversations | Triaging & Admitting

### When you’re deciding where a patient should go

<table>
<thead>
<tr>
<th>What They Say</th>
<th>What You Could Say</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why shouldn’t I just go to the hospital?</td>
<td>Our primary concern is your safety. We are trying to organize how people come in. <strong>You can help speed up the process for yourself and everyone else by _____________.</strong></td>
</tr>
<tr>
<td>Why are you keeping me out of the hospital?</td>
<td>I imagine you are worried and want the best possible care. Right now, the hospital should be for those that absolutely need it. <strong>The safest thing for you is to _____________.</strong></td>
</tr>
</tbody>
</table>

### When your patient needs the hospital, or the ICU

<table>
<thead>
<tr>
<th>What They Say</th>
<th>What You Could Say</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does this mean I have COVID19?</td>
<td>We will need to test you with a nasal swab, and we will know the result within the next few days. <strong>It is normal to feel stressed when you are waiting for results.</strong></td>
</tr>
<tr>
<td>How bad is this?</td>
<td>From the information I have now and from my exam, your situation is serious enough that you should be in the hospital. We will know more in the next day, and we will update you.</td>
</tr>
<tr>
<td>Is my grandfather going to make it?</td>
<td>I imagine you are scared. Here’s what I can say: because he is 90, and is already dealing with other illnesses, <strong>it is quite possible that he may die in the hospital. Honestly, it is too soon to say for certain.</strong></td>
</tr>
<tr>
<td>How can you not let me in for a visit?</td>
<td><strong>I so wish I could let you visit, because I hear it’s important to you.</strong> The risk of spreading the virus is so high that I am sorry to say we cannot allow visitors. We can help you be in contact electronically.</td>
</tr>
</tbody>
</table>
## Conversations | Counseling & Deciding

### When coping needs a boost, or emotions are running high

<table>
<thead>
<tr>
<th>What They Say</th>
<th>What You Could Say</th>
</tr>
</thead>
<tbody>
<tr>
<td>I’m scared.</td>
<td>This is such a tough situation. <strong>I think anyone would be scared.</strong> Could you share more with me?</td>
</tr>
<tr>
<td>I need some hope.</td>
<td>Tell me about the things you are hoping for? <strong>I want to understand more.</strong> What gives you hope on an ordinary day?</td>
</tr>
<tr>
<td>You people are incompetent!</td>
<td>I can see why you are not happy with things. <strong>I am willing to do what is in my power to improve things for you.</strong> What can I do to help?</td>
</tr>
<tr>
<td>Do I need to say my goodbyes?</td>
<td>I see you are worried. We are worried too. <strong>What’s most pressing on your mind?</strong> Are there people in your life that need to know you love them, even if things are fine?</td>
</tr>
</tbody>
</table>

### When things aren’t going well, goals of care, code status

<table>
<thead>
<tr>
<th>What They Say</th>
<th>What You Could Say</th>
</tr>
</thead>
<tbody>
<tr>
<td>I want everything possible. I want to live.</td>
<td>We are doing everything we can. This is a tough situation. Could we step back for a moment so I can learn more about you? <strong>What do I need to know about you to do a better job of taking care of you? What is important in your life?</strong></td>
</tr>
<tr>
<td>I don’t think my spouse would have wanted this.</td>
<td>Well, let’s pause and talk about what he would have wanted. <strong>Can you tell me what he considered most important in his life?</strong></td>
</tr>
<tr>
<td>I am not sure what my grandfather wanted—we never spoke about it.</td>
<td>You know, many people find themselves in the same boat. This is a hard situation. To be honest, given his overall condition now, if we need to put him on a breathing machine or do CPR, he will not survive. <strong>Given all this, I would recommend that we allow him to die peacefully and not try to restart his heart as I don’t think it will benefit him.</strong> I know that is hard to hear. What do you think?</td>
</tr>
</tbody>
</table>
## Conversations | Resourcing & Notifying

### When scarcity of resources forces triage and rationing

<table>
<thead>
<tr>
<th>What They Say</th>
<th>What You Could Say</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shouldn’t I be in an intensive care unit?</td>
<td>Your situation does not meet criteria for the ICU right now. The hospital is using special rules that let us use ICU beds fairly for everyone when there just aren’t enough of them. I wish this was a year ago, when we had enough beds. We’ll keep doing everything we can no matter which floor you are on.</td>
</tr>
<tr>
<td>My grandmother needs the ICU! Or she is going to die!</td>
<td>This is a scary situation, and I am also worried for your grandmother. Even if we could transfer her to the ICU, I am not sure she would live. We will continue to do everything we can for her.</td>
</tr>
<tr>
<td>Are you just discriminating against her because she is old?</td>
<td>No. We are using guidelines that were developed by people in this community--clinicians, policymakers, and regular people--to be sure that no one is singled out during this crisis. I know it is hard to hear.</td>
</tr>
<tr>
<td>Can’t you get 15 more ventilators from somewhere else?</td>
<td>Right now the hospital and hospitals around the country are operating over capacity. Unfortunately, it is not possible for us to increase our capacity like that overnight. I realize that is disappointing to hear.</td>
</tr>
</tbody>
</table>

### When you are telling someone over the phone

<table>
<thead>
<tr>
<th>What They Say</th>
<th>What You Could Say</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes I’m his daughter. I am 5 hours away.</td>
<td>I have something serious to talk about with you. Are you in a place where you can talk?</td>
</tr>
<tr>
<td>What is going on? Has something happened?</td>
<td>I am calling about your father. He died a short time ago. The cause was COVID-19.</td>
</tr>
<tr>
<td>[Crying]</td>
<td>My deepest condolences. [Silence. If you feel you must say something: “Take your time. I am here”].</td>
</tr>
<tr>
<td>I knew this was coming, but I didn’t realize it would happen this fast.</td>
<td>I can only imagine how shocking this must be. [Silence. Wait for them to restart]</td>
</tr>
</tbody>
</table>
## Conversations | Anticipating & Grieving

### When you’re worrying about what might happen

<table>
<thead>
<tr>
<th>What You May Fear</th>
<th>What You Can Do</th>
</tr>
</thead>
<tbody>
<tr>
<td>That patient’s son is going to be very angry.</td>
<td>Before you go in the room, take a moment for one deep breath. What’s the anger about? Love, responsibility, fear?</td>
</tr>
<tr>
<td>I don’t know how to tell this adorable grandmother that I can’t put her in the ICU and that she is likely going to die.</td>
<td>Remember what you can do: you can hear what she’s concerned about, you can explain what’s happening, you can help her prepare, you can be present. These are gifts.</td>
</tr>
<tr>
<td>I have been working all day with infected people and I am worried I could be passing this on to the people who matter most.</td>
<td>Talk to them about what you are worried about. You can decide together about what is best. There are no simple answers. And worries are easier to bear when you share them.</td>
</tr>
<tr>
<td>I am afraid of burnout, and of losing my heart.</td>
<td>Can you look for moments every day where you connect with someone, share something, enjoy something? Remember that whatever your own state, that these feelings (e.g. burnout, loss) are intrinsic to our human condition. Can you accept them, not try to push them away, and then decide what you need?</td>
</tr>
</tbody>
</table>

### When you’ve lost someone

<table>
<thead>
<tr>
<th>What You May Be Thinking</th>
<th>What You Can Do</th>
</tr>
</thead>
<tbody>
<tr>
<td>I should have been able to save that person.</td>
<td>Notice: am I grading myself? Could I step back and just feel? Maybe it’s sadness, or frustration, or just fatigue. Those feelings are normal. And these times are distinctly abnormal.</td>
</tr>
<tr>
<td>OMG I cannot believe we don’t have the right equipment / how mean that person was to me / how everything I do seems like it’s blowing up</td>
<td>Notice: am I catastrophizing? Is all this analyzing really about something else? Like how sad this is, how powerless I feel? Under these conditions, such thoughts are to be expected. Can we notice them, and feel them, maybe share them? And then ask ourselves: can I step into a less reactive, more balanced place even as I move into the next thing?</td>
</tr>
</tbody>
</table>
Techniques | Responding to Emotion

Naming and Validating - This response to emotion helps patients feel heard. We often name and validate strong emotions both negative and positive.
- “It makes perfect sense. It feels hard to live in this uncertainty.”
- “Wow, I see how happy you are that you are feeling better today and looking forward to your crossword puzzles!”

Normalizing - This tells people they are not alone with their emotions.
- “Most of my patients say the same things you are saying. It is so normal to feel scared that this is all happening.”

Aligning/non-abandonment - This tells patients and their loved ones that you are there for them.
- “I hear how hard it is to speak to your children about the pandemic. I want you to know that we will be here with you to help you navigate these conversations.”

Simple Reflection - This shows active listening.
- “I hear how very sad all of this is.”
- “I hear that you are worried about your sister”

Complex Reflection - This not only shows you are actively listening, it also helps to validate a hypothesis that you might thinking about the persons emotions.
- “I hear how sad this is and I wonder if it is even harder right now given that your daughter is going off to college?”
- “I hear how scared you are and I wonder if you are most scared about losing your dad?”

Curiosity - Be curious. This helps to build connection and helps you better understand emotions and situations.
- “What was that experience like for you? Tell me more about what specifically the hardest part was?”
Telemedicine | Communication Tips

During the COVID-19 pandemic, telemedicine is playing a key role for the UVM Health Network so that those who are symptomatic or wish to stay home can still connect with their clinicians. Below are helpful communication techniques that are unique to telemedicine encounters.

Introduction
This can be stressful and a new experience for patients who will need reassurance. It is important to orient them to the visit, setting expectations and the length of time. Also, let them know if something goes wrong you will call them back.

Environment
If you anticipate there will be expressions of strong emotions, make sure to cue the patient to be in a more private setting where they will feel comfortable expressing emotions. For example, they may not want to have the kids around.

Look into the Camera
Make sure you have your screen aligned in such a way that you can look into the camera directly, creating eye contact. Paradoxically, one trick is to use a smaller device (i.e., phone, tablet) to foster a more intimate connection. Background should be plain and without windows.

Attend to Environmental Cues
In telemedicine, we are invited into a patient’s inner world. What do you notice? For example, are they in a darkened room? Are they wanting to have a more superficial conversation today? These clues can help guide your questions and emotional responses.

Conveying Emotion
Visual gestures can convey empathy and connection such as touching your heart when expressing concern. You can also use verbal or sound cues to indicate you are listening.

Ending the Session
Ending a telemedicine session can feel very abrupt. We don’t get to walk the patient to the door and say goodbye. Think about how you might want to wind things down if a patient has expressed emotions. You may want to signpost that the appointment is coming to an end.

• “I see that we have about 10 minutes left. I wonder what might be most helpful to discuss as we finish up for today?

Be sure to include next steps and what to expect after the visit.
Fever is the most common symptom for patients infected with COVID-19. Fever has been reported in up to 85-99% of patients in some studies. Fevers can range from 37.5-40.0 Celsius (99.5-104 Fahrenheit), and are often intermittent.

**General Measures:**
- Use cool compresses; cover the patient with only a sheet.
- Monitor hydration and nutrition.

**Note:** While fans can be helpful for fevers, fans are not recommended in patients infected with COVID-19 as they have the potential to expand the range of droplets.

**Pharmacological Agents:**
- **Acetaminophen:** use as first-line treatment for fever.
  - Elimination half life is 2-3 hours in adults.
  - Can use oral, rectal or intravenous.
- **Ibuprofen:** second line agent.
  - Use with caution in renal disease or patients with a bleeding risk.

**In Actively Dying Patients:**
- For the unresponsive, actively dying patient, limit medical treatment of fever to those who appear to be suffering despite general fever measures.
  - Note temperature fluctuation may be part of the dying process and recalcitrant to antipyretics. In this case, education and reassurance of loved ones is the best intervention.

**Adult Dosing for Fever Medications**

**Acetaminophen**
- PO/PR: 325-650mg q4H PRN or scheduled
- IV: 650mg q6H PRN or scheduled
- Max 4g daily

**Ibuprofen**
- PO: 400-600mg q4H PRN or scheduled
- Max 2400-3200mg

**Peds Dosing for Acetaminophen**
- PO: 10-15 mg/kg/dose q4-6H PRN or scheduled
- PR: 10-20 mg/kg dose q4-6H PRN or scheduled
- Max 75mg/kg/day
- >50 kg use adult dosing
Symptom Management | Dyspnea

Severe and sometimes milder disease in people infected with COVID-19 can include dyspnea and hypoxia. Dyspnea is a subjective experience described as air hunger and is often accompanied by increased work of breathing. Best practice is to optimize non-opioid measures and, if insufficient, to use opioids for refractory dyspnea.

General Measures:
- Positioning (sitting up) and using pillows behind the patient’s neck and back to help expand the chest.
- Bedside relaxation techniques may be helpful.
- In the imminently dying patient, discontinuing parenteral fluids is appropriate.

Note: caution with using fans for patients infected with COVID-19 as it may increase droplet spread. Nebulized medications may also carry this risk.

Treatment with Oxygen:
- Oxygen is often, but not universally, helpful.
- Use for patients who have hypoxia (oxygen saturation<90%) or for patients whom you feel it may improve symptoms.
- Certain oxygen delivery methods (e.g. High Flow NC or BiPAP) may carry a higher risk of droplet spread in COVID-19.

Pharmacological Agents:
- Disease directed therapy: consider using diuretics or bronchodilators if there is evidence this will relieve symptoms.
- Opioids: drugs of choice for refractory dyspnea.
  - Low dose opioids have been shown to improve dyspnea.
  - Although morphine is more commonly studied in controlling dyspnea, most major opioids seem to have similar effects.
  - In nonverbal patients, medications should be given for increased work of breathing (e.g. accessory muscle use)
- Benzodiazepines: There is little evidence for the efficacy of benzodiazepines alone in treating dyspnea. However, they can be effective in treating concurrent anxiety.

Adult Dosing for Dyspnea Medications

Morphine
PO: 2.5mg-5mg q2H PRN
IV: 1-2mg q1H PRN

Hydromorphone
PO: 1-2mg q2H PRN
IV: 0.2-0.4mg q1H PRN

Lorazepam
PO or IV: 0.50-1mg q6H PRN

Pediatric Dosing for Dyspnea Medications

Morphine
PO: 0.1mg/kg q3-4H PRN
Max starting dose is 5mg
w/ close follow-up for adjustments to dose/frequency as needed.

Lorazepam
0.02-0.05 mg/kg q6H PRN
Max 2mg

Refer to general opioids information section if required

14
Dyspnea Management Protocol in the Opioid Naïve Adult Patient

**Step 1**
Optimize underlying disease treatment (e.g. extra diuresis, bronchodilators, etc.)

**Step 2**
Use supplemental oxygen for hypoxia or for symptomatic relief

**Step 3**
Start opioid (doses in morphine below; use morphine for GFR>30)
- PO (solution): 2.5-5mg q2H PRN
- IV/SQ: 1-2mg q1H PRN
- See guidelines in general opioids section

**Step 4**
Increase dose by 50% if dyspnea unrelieved from starting dose (e.g. 5mg-> 7.5mg)

**Step 5**
Call palliative care for assistance

Dyspnea Management Protocol in an Adult Patient Who Is Already Taking Opioids

**Step 1**
Optimize underlying disease treatment (e.g. extra diuresis, bronchodilators, etc.)

**Step 2**
Use supplemental oxygen for hypoxia or for symptomatic relief

**Step 3**
Utilize opioid
- Calculate 24-hour use and consider starting PRN dose equal to 10% of 24-hour total
- If no 24-hour reference: begin with home oral PRN dose; if home opioid is known to be ineffective consider increasing home dose by 50%

**Step 4**
Increase dose by 50% if dyspnea unrelieved from starting dose (e.g. 5mg-> 7.5mg)

**Step 5**
Referral to palliative care for assistance
Symptom Management | Pain

Headache and myalgia can be common symptoms in COVID-19 patients. Patients are unlikely to have extreme pain unless the patient has pain from underlying comorbidities.

Note on Preventing Constipation
For patient who are bedridden or taking scheduled opioids:
- **Polyethylene glycol**: give 17g by mouth daily. If no daily bowel movement increase to twice daily. And/or:
- **Senna**: take 8.6-17.2mg by mouth at bedtime. If no daily bowel movement increase to twice daily. And/or:
- **Dulcolax suppository**: 10mg per rectum every morning.

Peds Dosing for Pain Management

**Acetaminophen**
- PO: 10-15 mg/kg/dose q4-6H PRN
- PR: 10-20 mg/kg/dose q4-6H PRN
- Max 75mg/kg/day
- >50 kg use adult dosing

**Morphine**
- PO: 0.3mg/kg/dose q3-4H
- IV/SQ: 0.05-0.1 mg/kg/dose q2-3H w/ close follow-up for adjustments to dose/frequency as needed.

Acute Pain Adult Protocol

**Step 1**
Start Non-Opioids

**Acetaminophen**
- PO/PR/IV: 325-650mg q4H PRN; or schedule if pain is constant

**Ibuprofen**
- PO: 400mg q4H PRN or schedule if pain is constant

**Step 2**
Start Opioids

**Morphine** (for GFR>30)
- PO (solution or tablet): 7.5-15mg q2H PRN
- IV/SQ: 2-5mg 1H PRN

**Hydromorphone** (for GFR<30)
- PO: 2-3mg q2H PRN
- IV/SQ: 0.4-0.6mg q1H PRN

- Increase by 50% for pain unrelieved by starting dose.
- If a patient is using most PRNs, consider scheduling dose every 4H and add a breakthrough dose that represents 10% of 24hr dose every 1-2H PRN.

**Step 3**
Referral to Palliative Care

See guidance on acute crisis management for actively dying patients.

If no relief…
Symptom Management | Cough

Cough is also common in patients infected with COVID-19. In one study, 59% of patients reported cough with only 30% reporting sputum production.

General Measures:
Non-pharmacologic therapy is directed at the symptom rather than the underlying etiology, and it aims to control rather than eliminate cough
- Upright positioning reduces coughing secondary to reflux or aspiration.
- Humidified oxygen reduces dryness and irritation of airways.
- Encourage warm fluids, frequent sips of water.

Pharmacological Agents:
• Suppressants
  - Dextromethorphan: most commonly used antitussive.
    - May only be available in combination with guaifenesin.
  - Benzonatate: inhibits cough by anesthetizing stretch receptors in the respiratory tract.
    - It is not recommended in young children (<12Y).
  - All opioid analgesics have antitussive activity. For patients already taking opioids for other indications, there is no need to add another opioid.
• Mucolytics and Drying Agents
  - Guaifenesin: an expectorant that thins bronchial secretions and eases expectoration
    - May increase fluid in the respiratory tract, not recommended if the cough reflex is diminished
  - Anticholinergics (hyoscyamine or scopolamine): helpful in patients with copious upper respiratory secretions.

  • Bronchodilators
    - Have not been shown to be effective apart from specific indications (e.g., for COPD or asthma exacerbations).
    - If using bronchodilators, use non-nebulized forms such as inhalers with spacers for patients with COVID-19 infections.

Adult Dosing for Cough Medications
Dextromethorphan
PO: 10-20mg q4H PRN or scheduled
Benzonatate
PO: 100-200mg q4H PRN or scheduled
Guaifenesin
PO: 200-400mg q4H PRN or scheduled

Pediatric Dosing for Cough Medications
Dextromethorphan
Oral syrup (immediate release):
2-5 years: 5 mg q4H PRN, max 30mg/day (6 doses)
6-11 years: 10 mg q4H PRN, max 60mg/day (6 doses)
≥12/adolescents: 20 mg q4H PRN, max 120mg/day (6 doses)
Oral Guaifenesin syrup
2-5 years: 50-100 mg q4H PRN, max 600mg/day (6 doses)
6-11 years: 100-200 mg q4H PRN, max 1200mg/day (6 doses)
≥12 years: 200-400mg q4H PRN, max 2400mg/day (6 doses)
Symptom Management | Airway Secretions

Excessive secretions may be significant in severe COVID-19 infections. This is most likely to be a concern when the patient is in the dying process and unable to actively clear secretions because of lost reflexive swallow. In the case of the ‘death rattle’, if recalcitrant to below interventions, the best intervention is education and reassurance to family that the patient is not suffering and that the noise is a natural part of the dying process.

General Measures:
- Reposition patient (especially propped on their side to allow for postural drainage and opening the upper airway).
- Gentle oropharyngeal suctioning (avoid deep suctioning in dying patients).
- Limit fluids introduced into the mouth and switch oral/sublingual medications to other routes.
- Limit or stop IV fluids and enteral feedings.

Pharmacological Agents:
We recommend limiting medical intervention to patients who appear to be suffering from excessive secretions (including causing worsening dyspnea, choking/gagging, cough) despite non-pharmacological interventions.

Note: these medications may lead to uncomfortable dryness and more viscous/difficult to clear secretions.

- **Glycopyrrolate**: first-line agent for copious secretions
  - Does not cross the blood brain barrier and reduces possibility of delirium
- **Atropine Ophthalmic 1% Solution**: second-line agent
  - Given sublingually to dry up future secretions
- **Scopolamine Patch**: only for severe cases given higher risk of delirium
  - Onset ~12 hours and ~24 to steady state
  - Only use for adolescents and adults.

### Pediatric Dosing for Secretion Medications

**Glycopyrrolate**
- IV/SQ: 0.004-0.01 mg/kg/dose q4H PRN

**Atropine 1%**
- 1 drop SL q4H PRN

### Adult Dosing for Secretion Medications

**Glycopyrrolate**
- IV: 0.2mg-0.3mg q4H PRN or scheduled
- Atropine ophthalmic 1% solution
  - SL: 0.2mg-0.3mg q4H PRN or scheduled
- Scopolamine Patch
  - Transdermal: 1.5mg patch q72H
Symptom Management | Nausea/Vomiting

Nausea and vomiting may be a symptom of COVID-19, though a patient’s course may be complicated by other causes as well (e.g. uremia, adverse reaction to medications, headache, anxiety, constipation, excessive secretions). The etiology is often multifactorial, and treatment begins with identifying and modifying most likely causes.

General Measures:
- Minimize triggers (viscous fluids, smells, etc.).
- Optimize mouth care and non-oral routes of medications.
- Opioid rotation (morphine is especially likely to cause nausea).

Pharmacological Agents:
- **Ondansetron**: first-line without clear etiology/multifactorial.
  - Can cause constipation and prolong QTC interval.
- **Prochlorperazine**: preferred for opioid related nausea
  - Can cause dry mouth.
- **Haloperidol**: also used for medication related nausea.
- **Metoclopramide**: first line for dysmotility or partial bowel obstructions.
- **Lorazepam**: first line for anxiety associated nausea.

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**Adult Dosing for Antiemetics**

**Ondansetron**
PO/IV: 4-8mg q6-8H PRN or scheduled

**Prochlorperazine**
PO/PR/IV: 5-10mg q6-8H PRN or scheduled

**Haloperidol**
PO: 0.5mg-1mg q6H PRN or scheduled
IV: 0.25-0.5mg q6H PRN or scheduled

**Metoclopramide (for dysmotility)**
PO/IV: 5-10mg q4-6H PRN or scheduled

**Lorazepam (anxiety related)**
PO/IV: 0.5-1mg every 6H PRN or scheduled

---

**Pediatric Dosing for Antiemetics**

**Ondansetron**
PO/IV: 0.15mg/kg q8H PRN
Max 16mg

**Prochlorperazine**
0.1mg/kg q6-8H PRN

**Haloperidol**
>3yrs: 0.01 - 0.025 mg/kg q8H PRN
Max 0.15 mg/kg/day

**Lorazepam**
0.02-0.05 mg/kg q6H PRN
Max 2mg
Symptom Management | Agitated Delirium

Change in mental status is possible in patients infected with COVID-19 particularly with more severe forms of disease. Attempt to reverse potential causes of agitation/delirium in COVID-19 infections when possible (e.g., treat infection/metabolic derangement, reduce fever, treat exacerbating symptoms like insomnia and pain, limit/change sedating medications, etc.).

General Measures:
- Limit disrupting noise.
- Optimize sleep-wake pattern.
- Monitor hydration and nutrition.
- Reduce lines/tubes attached to patient as much as possible.
- Encourage mobility when possible.
- Minimize turning and invasive personal care as much as possible and consider medicating patient prior to necessary care.

Pharmacological Agents:
- **Haloperidol**: first-line treatment for patient with moderate to severe agitated delirium.
- **Olanzapine and Risperidone**: can be used if delirium persists for greater than 48 hours and is refractory to haloperidol.
- **Lorazepam**: If symptoms persist, can consider adding or replacing antipsychotics with lorazepam particularly if there is anxiety component.
  - May cause paradoxical delirium in older patients.

(See protocol on next page)
Symptom Management | Agitated Delirium

Acute Agitation/Delirium/Restlessness/Confusion Protocol

**Step 1**
Full examination
- Look for sources of distress including constipation, urinary retention, pressure ulcers and manage accordingly.

**Step 2**
Review medication list and delete all non-essential medication to reduce anticholinergic burden.

**Step 3**
Non-opioid for suspected fever or pain
- Doses described in the fever or pain sections of this document.

**Step 4**
Opioid for pain or dyspnea
- Doses described in the dyspnea or pain sections of this document.

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**Step 5**
Start haloperidol (Haldol)
PO (solution or tablets): 1mg q1H until calm, increase to 2mg if no relief from starting dose
IV: 0.5mg q1H until calm, increase to 1mg if no relief from starting dose
- If effective, use total dose every 4-6H PRN
- Add Olanzapine or Risperidone if persistent >48hrs

**Step 6**
Start lorazepam (Ativan)
PO/IV: 0.5mg q1H until calm, increase to 1mg if no relief from starting dose
- If effective, use total dose every 8H PRN; can be used with antipsychotics.

**Step 7**
Referral to Palliative Care
End of life care generally refers to caring for a patient in the final hours to days of life. Important aspects in caring for a patient at the end of life include intense symptom management, clear and empathic communication with families, and ensuring psychosocial and spiritual support for both the patient and family. **Good palliative care (or at the end of life, hospice care) does not hasten death.**

**Dyspnea and Pain Management at the End of Life**

- Treat patient-reported pain or dyspnea and/or physical signs of increased work of breathing including use of accessory muscles, tripod positioning, grimacing, and tearfulness or moaning.
- Remember that respiratory rate can be variable depending on physiologic conditions (i.e. acidosis or increased ICP creates change in respiratory rate), and treating to reduce respiratory rate alone without signs of increased work of breathing is not clinically indicated.
- Breathing patterns will change at the end of life. Respirations will become shallow, the rate will become either slower or more rapid, and there will be periods of apnea.

**Using Infusions for Dyspnea or Pain at the End of Life:**

- Infusions can take up to 20 hours to reach steady state and thus are not effective for managing acute symptoms.
- Boluses can be given every 15 minutes and more rapidly titrated to achieve better symptom control.
- Even if an infusion or scheduled dosing is started, always continue to use PRN doses for acute symptoms.

**Starting Infusions:**

- If more than 6 PRNs in a 4 hour period:
  - Calculate opioid total in 4 hours and divide by 4 (or total PRN/# hours) for initial infusion rate.
  - Consider reducing initial rate by 25-50% if concerned about side effects.
- If a patient is on a long-acting opioid, can no longer take oral, and it is appropriate to consider an infusion:
  - Calculate total long acting opioid and divide by 24, consider reducing by 50% for initial infusion rate
- Once infusion rate is determined, add PRN as 10% of daily total or roughly twice the infusion rate.
- Clinicians may choose to begin opioid infusions for patients dying from COVID-19 infections earlier than in other diseases to minimize exposure to the virus.

**Titrating Infusions:**

- In general, infusions should not be titrated more than every 12H because of time to reach steady state.
- For actively dying patients, we recommend that opioid infusions not be increased more frequently than every 4 hours.
  - Instead, use boluses every 15min to achieve symptom relief.
- Increases can be made by calculating total PRN over 12-24 hours and dividing by the number of hours (total PRN over/# hours), then adding 50-75% of this number to the current infusion rate.
  - For each increase, do not increase more than 100% of the previous infusion rate as this can exacerbate side effects.
Symptom Management | Actively Dying

Dyspnea/Pain Crisis in Actively Dying Patients Protocol

Administer IV or SQ opioids as follows
(Doses below are based on opioid naïve patient, doses may differ for opioid tolerant patients; example below is for morphine but hydromorphone and fentanyl can also be used)

**Step 1**
Give 1st dose:
- 2mg IV and wait 15 minutes
- If effective make 2mg q15 min PRN available

**Step 2**
Give 2nd dose:
- 2mg IV and notify the prescriber; wait 15 minutes
- If effective make 4mg q15 min PRN available

**Step 3**
Give 3rd dose:
- 4mg IV (2x starting dose) and wait 15 minutes
- If effective make 4-8mg q15 min PRN available

**Step 4**
Give 4th dose:
- 4 mg IV and consider calling the palliative care pager; wait 15 minutes
- If effective make 8-12mg q15 min PRN available

**Step 5**
Give fifth dose:
- 8 mg (4x starting dose)
- Follow up with palliative care team

**If no relief...**

**Note:** At some institutions, an “End of Life Order Set” is available. It is recommended that clinicians take into account the above information considering pharmacokinetics and the most recent regimen to determine whether the order set is appropriate or needs to be tailored further for the specific patient.
When To Call A Palliative Care Specialist
Specialist Palliative Care for COVID-19

Palliative Care remains a resource for primary care providers and inpatient teams for consultation regarding difficult symptom management and complex medical decision making.

The COVID-19 pandemic will likely pose challenging questions and prompt difficult conversations and choices. While triage decisions about resource allocation, if needed, will be made at the institutional level, we are available for the following needs:

- **Physical symptoms** that are either difficult to control or refractory to basic management;

- **Difficult decisions and discussions** regarding goals of care after initial attempts by primary team;

- **Challenging communication** issues with patients and/or caregivers; refractory emotional or spiritual distress in persons grappling with meaning, purpose, and connection;

- **Caregiver or team distress** that have not improved after initial attempts to console; or,

- **Inter- or intra- team conflicts** that are refractory to initial attempts to mediate.
# Calling a Palliative Care Specialist

## How to Reach Palliative Care

<table>
<thead>
<tr>
<th>Location</th>
<th>Weekdays</th>
<th>Nights &amp; Weekends</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UVM Medical Center</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Division of Palliative Medicine</td>
<td>Page triage clinician through PAS: 802-847-2700</td>
<td>Page on-call clinician through PAS: 802-847-2700</td>
</tr>
<tr>
<td><strong>Central Vermont Medical Center</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palliative and Spiritual Care Team</td>
<td>Page Elaine Hafter: 802-452-7949</td>
<td>Page Dr. Jonna Goulding: 802-452-7806</td>
</tr>
<tr>
<td><strong>Porter Hospital</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palliative Care Team</td>
<td>Call Taylor Zak: 802-388-4782</td>
<td>Page on-call clinician through PAS: 802-847-2700 or reach out to Dr. Diana Barnard</td>
</tr>
<tr>
<td><strong>Champlain Valley Physicians Hospital</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palliative Care Team</td>
<td>Call clinical team: 518-562-7998</td>
<td>Page on-call clinician: 518-562-7998</td>
</tr>
<tr>
<td><strong>UVM Home Health and Hospice</strong></td>
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</tr>
<tr>
<td></td>
<td>Call clinical team: 802-860-4410</td>
<td>Page on-call Hospice Medical Director through PAS: 802-847-2700</td>
</tr>
</tbody>
</table>
Appendix

- General Opioid Information
- Empathetic Continuers
- More COVID-19 Related Conversations Tips
- References
Appendix | General Opioid Information

- Morphine is generally the first line, unless renal impairment (GFR<30) or allergy.
- If a patient has renal impairment consider use of hydromorphone or IV boluses of fentanyl.
  - Note: hydromorphone can still cause neurotoxicity in renal failure but does so less than morphine.
- Opioids are the gold standard treatment of dyspnea refractory to optimization of underlying disease. Medication should be titrated to feeling of dyspnea or physical exam (e.g. work of breathing)

Understanding pharmacokinetics is essential for good symptom control

- Liquid forms of morphine/oxycodone/hydromorphone are all absorbed in the gut, not via oral mucous membranes (buccal).
- Oral forms of medication can take 1 hour to reach peak effect.
- IV forms of medication can reach peak effect in 15 minutes.
- Subcutaneous forms of medication can reach peak in 20-30 minutes.
- Infusions take multiple hours (up to 20) to achieve a steady state.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Oral Dose (mg)</th>
<th>Intravenous Dose (mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>30</td>
<td>10</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>20</td>
<td>n/a</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>7.5</td>
<td>1.5</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>n/a</td>
<td>0.1 (100mcg)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Oral Dose (mg)</th>
<th>Intravenous Dose (mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>5-7.5mg</td>
<td>1-2mg</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>1-2mg</td>
<td>0.2-0.4mg</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>2.5mg</td>
<td>--</td>
</tr>
</tbody>
</table>
### Appendix | Empathic Continuers (NURSE)

<table>
<thead>
<tr>
<th><strong>Example</strong></th>
<th><strong>Notes</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Naming</strong></td>
<td>“You seem upset”</td>
</tr>
<tr>
<td>Name the emotion you see in front of you</td>
<td>“This must be overwhelming”</td>
</tr>
<tr>
<td>In general, turn down the intensity a notch when you name the emotion</td>
<td></td>
</tr>
<tr>
<td><strong>Understanding</strong></td>
<td>“I can’t begin to understand how hard this has been”</td>
</tr>
<tr>
<td>Try to put yourself in their shoes</td>
<td>“I can’t imagine what you are going through”</td>
</tr>
<tr>
<td>Think of this as another kind of acknowledgment, but stop short of suggesting you understand everything (you don’t)</td>
<td></td>
</tr>
<tr>
<td><strong>Respecting</strong></td>
<td>“I can see how hard you have been working to stay healthy”</td>
</tr>
<tr>
<td>Demonstrate respect for the person in front of you</td>
<td>“I can see what an amazing advocate you are for your mother”</td>
</tr>
<tr>
<td>Remember that praise also fits in here, e.g. “I think you have done a great job with this”</td>
<td></td>
</tr>
<tr>
<td><strong>Supporting</strong></td>
<td>“I will do my best to make sure you have what you need”</td>
</tr>
<tr>
<td>Demonstrate your ongoing support</td>
<td>“We will be here for you”</td>
</tr>
<tr>
<td>Making this kind of commitment is a powerful statement</td>
<td></td>
</tr>
<tr>
<td><strong>Explore</strong></td>
<td>“Tell me more”</td>
</tr>
<tr>
<td>Learn more about what the person is feeling, especially if you don’t understand</td>
<td>“Could you say more about what you mean when you say...”</td>
</tr>
<tr>
<td>If it’s a cognitive way of expressing emotion, explore why they ask the question</td>
<td></td>
</tr>
</tbody>
</table>
## Appendix | More COVID Conversations Tips

<table>
<thead>
<tr>
<th>What They Say</th>
<th>What You Could Say</th>
</tr>
</thead>
<tbody>
<tr>
<td>How come the basketball players got tested?</td>
<td>I don’t know the details. What I can tell you is that was a different time. <strong>The situation is changing so fast that what we did a week ago is not what we are doing today.</strong></td>
</tr>
<tr>
<td>I don’t want to come to the end of my life like a vegetable being kept alive on a machine [in a long term care facility or home].</td>
<td>I respect that. Here’s what I’d like to propose: we will continue to take care of you. <strong>The best case is that you don’t get the virus. The worst case is that you get the virus despite our precautions</strong>—and then we will keep you where you are and make sure you are comfortable for as long as you are with us.</td>
</tr>
<tr>
<td>Are you saying that no one can visit me?</td>
<td>I imagine it is hard to not have visitors. The risk of spreading the virus is so high that I am sorry to say we cannot allow visitors. You can use your phone or FaceTime, although I realize that is not quite the same.</td>
</tr>
<tr>
<td>I want to talk to your boss.</td>
<td>I can see you are frustrated. I will ask my boss to come by as soon as they can. Please realize that they are juggling many things right now.</td>
</tr>
<tr>
<td>I don’t want to end up being a vegetable or on a machine. [in the hospital]</td>
<td><strong>Thank you, it is very important for me to know that.</strong> Can you say more about what you mean?</td>
</tr>
<tr>
<td>Why can’t my 90 year old grandmother go to the ICU?</td>
<td>This is an extraordinary time. <strong>We are trying to use resources in a way that is fair for everyone.</strong> Your grandmother’s situation does not meet the criteria for the ICU today. I wish things were different.</td>
</tr>
</tbody>
</table>
### Appendix | More COVID Conversations Tips

<table>
<thead>
<tr>
<th>What They Say</th>
<th>What You Could Say</th>
</tr>
</thead>
<tbody>
<tr>
<td>You’re treating us differently because of the color of our skin.</td>
<td>I can imagine that you may have had negative experiences in the past with health care simply because of who you are. That is not fair. The situation today is that our medical resources are stretched so thin that we are using guidelines that were developed by people in this community, including people of color, so that we can be fair.</td>
</tr>
<tr>
<td>It sounds like you are rationing.</td>
<td>These are extraordinary times. <strong>What we are doing is trying to spread out our resources in the best way possible.</strong> This is a time where I wish we had more for every single person in this hospital.</td>
</tr>
<tr>
<td>You’re playing God. You can’t do that.</td>
<td>I didn’t mean to give you that feeling. <strong>Across Vermont, every hospital is working together to try to use resources in a way that is fair for everyone.</strong> I realize that we don’t have enough. I wish we had more. Please understand that we are all working as hard as possible.</td>
</tr>
<tr>
<td>How can you just take her off a ventilator when her life depends on it?</td>
<td>I can’t even imagine how hard this is for you and your family. Unfortunately, her condition has gotten worse, even though we are doing everything. Because we are in extraordinary times, we are following special guidelines that apply to everyone here. We cannot continue to provide critical care to patients who are not getting better. <strong>Because your wife will likely die even on the ventilator, we will plan to take her off of it and continue to care for her in the best way possible.</strong> I know that is hard to hear.</td>
</tr>
</tbody>
</table>
References


Images: Courtesy of Hush Naidoo; CDC; Fusion Medical Animation, and Adobe.