Managing Respiratory Symptoms of COVID-19 at End of Life

Primer for Front Line Health Care in Hospital

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Presenters

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Conflict of Interest

The presenters have no conflicts of interest to declare

Goals of this Presentation

- To familiarize front line staff in Hospital with what to expect and management of respiratory symptoms and accompanying symptoms of patients who have COVID-19 at end of life

- To improve comfort level of healthcare workers in supporting people at end of life related to respiratory illness

COVID-19

- Coronavirus (COVID-19) is a new respiratory illness with the ability to spread from person to person

- First identified in the city of Wuhan, China and has since travelled around the world causing a Global Pandemic

- There are currently >38,000 confirmed cases in Canada and 12 245 (6221 resolved cases, 659 deaths) in Ontario with the numbers rising each day

Risk factors for severe illness and death

- Male

- 60 years of age and older

- High blood pressure
- Diabetes
- Heart conditions
- Cancer
- Chronic lung disease
- History of strokes

Symptoms COVID-19

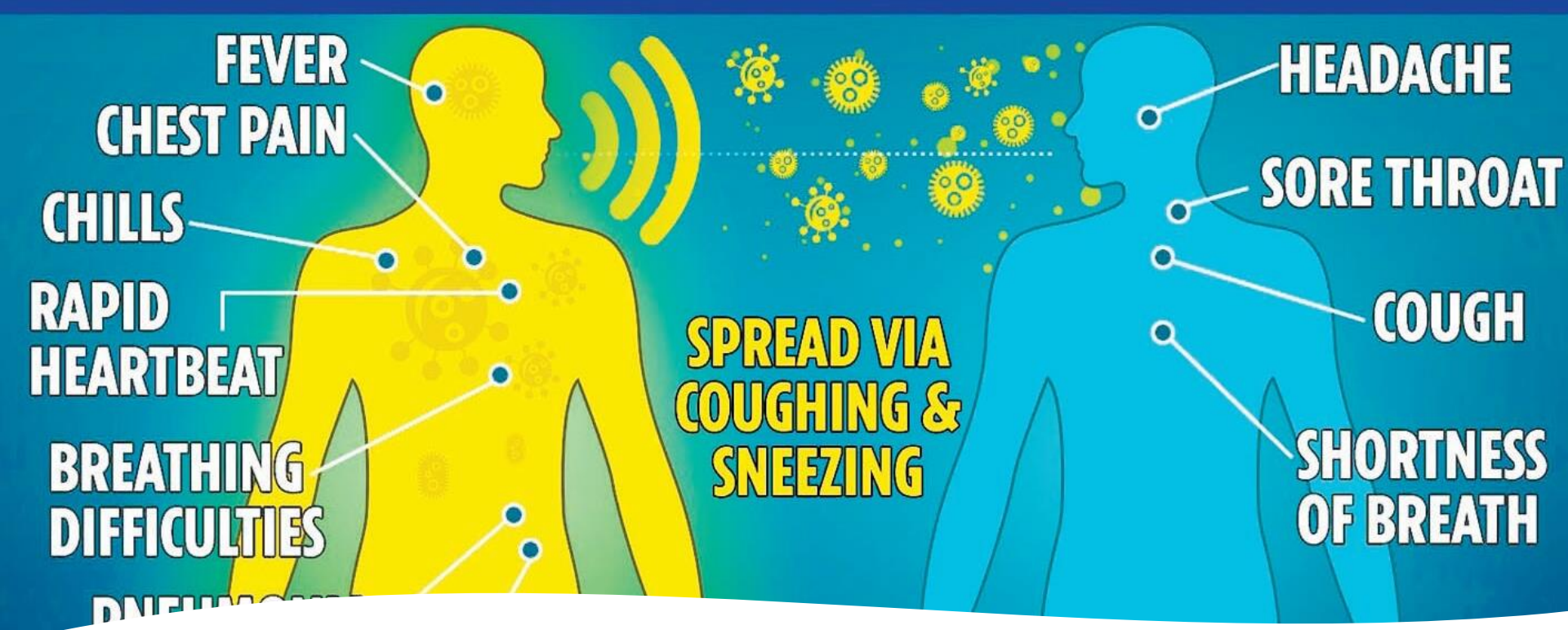
COVID-19 causes mild to severe respiratory illness similar to the influenza virus

2 to 11 days after exposure symptoms may include:

- fever, headache, dry cough, myalgias/back pain, abdominal discomfort, nausea, loss of smell, appetite, fatigue (common flu type symptoms)

With progression

- Could involve increased shortness of breath, pneumonia (day 5)
- Overwhelming acute respiratory distress, multiple organ failure (day 10)



COVID-19

- 80% of cases will have mild to moderate illness
- 14% of cases are considered severe
- 6% of cases will be considered critical and require ICU admission

COVID + Patients currently in Ontario as of April 22:

- 878 hospitalized
- 243 ICU
- 192 vented

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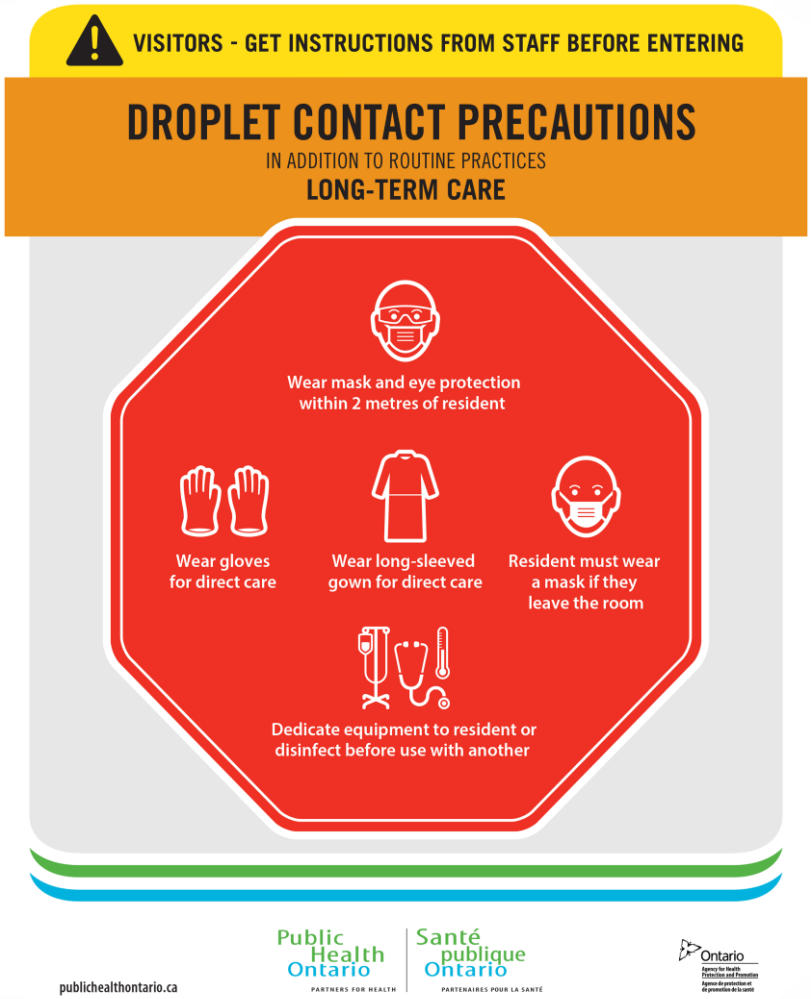
How to Provide Safe Care with COVID-19



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Location of Care for Patients

Treatment of COVID-19 is entirely supportive care

- limited role at present for any other medications (i.e. no use for antibiotics or antivirals)

- Abysmal recovery rates for those with comorbidities who require ventilation

Goal in caring for those admitted to Hospital

- Transferring to hospital are for those who have severe respiratory symptoms and require increased support

- Transitions within hospital: diagnosis, aggressive symptom management, ICU admission, palliative sedation, end of life care

Location of Care for Patients Cont'd

- Access to ICU and mechanical ventilation is on a as needed basis and in crisis will be triaged per provincial guidelines

- Strict adherence to preventative measures, visitor policies etc. will be very challenging to patients, families and friends of patients

Dyspnea Picture

- Patient reports SOB
- May appear to be fearful such as eyes wide open, panicked
- Areas around mouth and nail beds may be blue, dusky appearance
- Removing of O2 tubing
- Changes in circulation i.e. mottling
- Nasal flaring
- Use of accessory muscles to breath
- Hyperventilation
- Exertion such as position changes and toileting may bring on dyspnea
- Eating, drinking and conversation increase feeling of dyspnea (or exacerbate cough)
- cough may be dry or wet sounding but in COVID -19 noted as dry most often

Levels of dyspnea

Mild

1. Usually sit or lie quietly, little anxiety
2. Worsens with exertion
3. Breathing not observed as labored

Moderate

1. Usually persistent
2. SOB worsens with exertion, settles partially with rest
3. Pause while talking every 5-15 sec.
4. Breathing mildly laboured on observation

Levels of Dyspnea

Severe

1. Anxiety present
2. +/- onset confusion
3. Labored breathing awake & asleep
4. Pause while talking every few seconds

Extreme

1. Very frightened
2. Talk only 2-3 words between gasps
3. Exhausted - sit & lean, fall back
4. Total concentration on breathing
5. +/- confusion

Management of Dyspnea

Non-pharmacologic

- Positioning
- Loose clothing, avoid irritants

Pharmacologic

- **Opioids first line**
- O2 (less than 6L/min, unless in a negative pressure room)
- Inhalers (NO NEBULIZERS, **unless** in a negative pressure room)
- Benzodiazepines (lorazepam/midazolam) for associated anxiety
- Nozinan second line
- In refractory dyspnea consult with team/ PC consultant for palliative sedation

Do Not Use

- Fans
- Avoid deep suctioning

Unless in a negative pressure room avoid:

- Oxygen flow greater than 6L/min
- High flow nasal cannula oxygen
- CPAP or BiPaP
- Nebulized treatments

Symptom Management

Supporting the patient and family:

- Emphasize what you are **going to do**, not what you are **not able to do**

- Offer a healing presence, even if not physically present

Symptom Management: Respiratory Secretions

- Clearing of throat
- Weakened cough
- Lung secretions can be heard upon auscultation

Symptom Management: Respiratory Secretions

Non-pharmacologic

- Repositioning
- Mouth Care

Pharmacologic

- Stop IV fluids
- Atropine drops
- Glycopyrrolate/scopolamine
- Possible role for Lasix

Symptom Management: Respiratory Secretions

Supporting patient and family:

- Reassurance around the noises they may hear
- Explanation of care being provided

Symptom Management: Restlessness/Agitation

Restlessness/agitation at end of life:

- Crying out
- Pulling at tubes, clothing, grabbing at the air
- Visual hallucinations

Symptom Management: Restlessness/Agitation

Ensure that other symptoms are appropriately managed

Non-pharmacologic

- Reduce stimulation in patient environment
- Gentle reassurance
- Avoid physical restraints
- Correct sensory deficits

Pharmacologic

- Haldol(1st line)
- Nozinan (if Haldol is not effective)
- Midazolam

Symptom Management: Restlessness/Agitation

Supporting patient and family

- Reassurance
  - Using technology to connect
  - Explaining the potential cause of the agitation
  - Explaining treatments

How We Can Prepare

- Ensure knowledge of your patients' goals of care
- Prepare patient, families with what to expect, commitment to providing care
- Familiarize yourself with symptom management medications and palliative care/palliative sedation order sets
- Familiarize yourself with the pumps that will be used for medication delivery on your unit

Caring for the Family from a distance

- Actively listen
- Explain what you are seeing
- Reassure what you are actively doing
- Offer remote connection
- Verbal cues versus visual cues that you care
  - “I can’t imagine how hard this is…”
  - “ I hear you…”

Holding Space for the Emotional Experience

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Supports and Resources

Nurse managers/clinicians

Most responsible practitioner – MD/ NP

Consider involvement of Specialist

- Palliative Care Specialist
- Respiratory Therapist

Updated Palliative Order sets

- General Palliative Admission Order Set
- Palliative Sedation Order Set

Grief and Bereavement (e.g. chaplain, social work)

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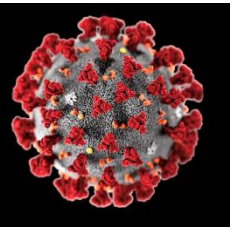
NEW COVID-19 RESOURCES



COVID-19 SPECIFIC CONVERSATION GUIDES:

- Proactive Goals of Care (GOC) conversations
- GOC conversations for a person with mild/mod COVID-
- GOC conversation for a person with severe COVID-19
- Phone conversations with families of a dying person

OTHER COVID RESOURCES:

- Palliative symptom management suggested order set for LTC
- Advance Care Planning guides for patients and SDM
- Sample letter from LTC facilities to families and residents

ALWAYS AVAILABLE:

- Advance Care Planning, Goals of Care and Consent resources for healthcare providers (conversation guides, e-learning modules)
- Person-Centred Decision-Making Toolkit

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Summary

- Communication is key to patient, family and health care staff
- A number of patients will die from this – our actions and ability to care for them will have lasting effects on families, colleagues, ourselves
- Engage in meaningful conversation on goals of care and share our knowledge on what to expect and how we will commit to their care
- We have the tools and knowledge to provide the comfort and care needed, be prepared