Many thanks to CCCC’s Sustaining Supporters who make it possible for us to continue to do this important work.
Thank you to our COVID Conversations Webinar Series Sponsors
COVID-19 Conversations Toolbox

coalitionccc.org/covid-conversations-toolbox/

The COVID-19 pandemic makes the threat of serious illness frighteningly real — and greatly emphasizes the need to know each patient’s values and wishes regarding treatment options. Conversations around serious illness and medical treatment options can be very empowering. Patients are often relieved to be asked about their values and wishes, family members avoid the anguish of guessing what the patient would want, and medical providers can more confidently in providing patient-centered care.

The Coalition for Compassionate Care of California is the respected voice for advance care planning and palliative care in California, with nearly 30 years of experience in creating a range of resources and educational materials to support healthcare providers and consumers. We’ve gathered together some of our best resources, as well as those of other respected leaders, in this COVID Convepersons Toolbox to provide easy access and support for healthcare providers and consumers as they navigate decision-making during these times challenging times. We will be regularly updating this resource as additional materials are added or identified.

Conversation Tools

Decision aids, COVID-specific analog, conversation tips, and other tools to help facilitate conversations about care during serious illness and COVID-19.

Advance Directives

Downloadable advance directive forms, tools, and resources to support creating advance directives.

POLST

Physician Orders for Life-Sustaining Treatment (POLST) form, FAQs, best practices, and other POLST resources.
Symptom Management of COVID-19 in Senior Living Facilities

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Why symptom management is important for COVID-19 pts

- COVID-19 can cause severe symptoms
- There is no virus-specific treatment yet
  - Symptom management will be the main treatment
- Some patients’ GOC in nursing homes will be comfort measures only and no hospital transfer
  - You should know how to treat symptoms
  - Typically, no palliative care consult is available in nursing homes
- Hospice referral of COVID-19 pts can be challenging
  - You should be able to manage symptoms without help from hospice
Symptoms of COVID-19

Common
- Fever
- Cough
- Shortness of breath

Less Common
- Chills
- Sore throat
- Muscle pain
- Chest pain
- New loss of taste or smell
- Nausea
- Diarrhea
Clinical course of hospitalized pt with COVID-19

Hospitalized pts (N=191), age 56y (46-67)

Time from illness onset to symptoms

- Fever: 1d (IQR 1-1)
- Cough: 1d (1-3)
- Dyspnea: 7d (4-9)
- ARDS: 12d (8-15)

Zhou et al. Lancet. 2020;395:1054
Acute Respiratory Distress Syndrome by COVID-19

Types of clinical courses of COVID-19 in nursing homes

- **Indolent course, deadly**
  - Initial 24-28 hours of fever and severe respiratory symptoms
  - Stabilization for 3-5 days
  - Decompensation on days 5-7 with death within 24 hours

- **Acute respiratory failure**
  - Symptoms begin with fever and acute respiratory failure with death within 6-12 hours.

- **Indolent course, convalescence**
  - Majority of our patients. Same course as indolent to death although continued improvement over 7-10 days.

*Modified from: Lessons Learned from the COVID-19 Outbreak at Canterbury Rehab, 3/29/2020 (by Jim Wright)*
Asymptomatic patients in nursing homes

The residents (N=76) in a facility in King County, WA, were offered COVID-19 testing as part of a facility-wide point-prevalence survey.

48 of the 76 residents were positive for COVID-19.

27 of the 48 residents (56%) were asymptomatic at the time of testing.

However, 24 of the 27 residents subsequently developed symptoms (median time to onset, 4 days).

Prognosis of nursing home residents

101 residents (median age 83, range 51 to 100) at a LTC in King County, WA, tested positive for COVID19

- Hospitalization 54.5% (55 of 101)
- Fatality rate 33.7% (34 of 101)

Important points of the COVID-19 clinical course

- Difficult to predict which patients deteriorate
- Many pts in nursing homes with COVID-19 do recover
- Respiratory failure happens around day 7 (±3 days)
- Once severe respiratory distress happens, pt typically dies rapidly (hours to a few days)
- Onset of symptoms to death is relatively short (7-10 days)
- COVID-19 is highly contagious
That means….

- Clarification of the goals of care is crucial
- Prepare for rapid development of severe dyspnea
  - Prescribe Comfort Kits (morphine, lorazepam etc) EARLY
- Many pts can develop severe dyspnea at the same time (around day 7)
  - Staff can be overwhelmed
- The family needs to be informed in advance of the possible rapid decline
- It may be challenging to decide the timing of hospice referrals
- Consider creative methods in order to reduce physical contact with pts
  - Video monitoring, “around the clock” administration of medications, start long-acting opioids early
Hospice referrals of patients with COVID-19

- Since many of COVID-19 pts recover, COVID-19 itself is not always a terminal diagnosis
- Two scenarios of hospice referrals
  - Pt with existing terminal conditions (metastatic cancer) who contracted COVID-19
  - Pt with COVID-19 who developed acute respiratory failure
- COVID-19 pts with acute respiratory failures die rapidly
  - May not have time for a hospice referral
- Some hospice agencies may not accept COVID-19 pts
- Difficult balance between benefits (access to hospice medical directors, family support, bereavement service) and risks (infection risks, PPE consumption)
- Visitor restrictions complicate enrollment process
Preparing for COVID-19: Three Things to Know

1. Pick someone to be your health care decision-maker.
   Choose someone you trust to make decisions for you if you become too sick to make them yourself.

2. Talk about what matters most to you.
   Talk to those who matter most to you about what matters most to you.

3. Think about what you would want if you became seriously ill with COVID-19.
   Think about what worries you most about becoming seriously ill, what’s most important to you, and what kind of treatments you would want.

- Hospitalization or staying in nursing homes?
- DNR? DNI?
Pharmacodynamics of opioids

<table>
<thead>
<tr>
<th></th>
<th>Peak effect</th>
<th>Duration of effect</th>
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<tbody>
<tr>
<td>PO</td>
<td>30-60 min</td>
<td>3-4 hours</td>
</tr>
<tr>
<td>IV</td>
<td>5-15 min</td>
<td>3-4 hours</td>
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Time to peak effect is the same for analgesia, relief of dyspnea, and sedation.

That means that the pt needs to be assessed 1 hour after PO opioid for an effect.

(Waiting longer does not give additional effect)

Duration of the effect can prolong to 6 to 8 hours depending on renal/hepatic function.
Opioids in renal impairment

Even though morphine is usually the first choice, Morphine is NOT recommended for CrCl < 30 (not creatinine)

(Morphine can be used in renal failure if the pt is actively dying)

Safer opioids in renal failure

1. Fentanyl (and methadone)
2. Hydromorphone
3. Oxycodone
Symptoms to Cover

- Dyspnea
- Cough
- Excess secretions
- Acute pain
- Delirium
- Nausea
- Diarrhea
- Fever
Dyspnea: Assessment

- Dyspnea is subjective
- Do not rely on SpO2
- Dyspnea may be described as breathlessness, inability to take a deep breath, “air hunger,” or chest tightness.
- The patient may engage in pursed-lip breathing and also may express anxiety, fear, or panic.
Assessment of dyspnea on patients with dementia

- Do: Ask them about their current state (“Do you have any trouble breathing now?”)
- Don’t: Ask them about the past dyspnea (you would get just confused)
- Try other words (choking, tightness, gasping for air, etc.)
- Give time for a response
- Pay attention to nonverbal clues: grimacing/frowning, irritability, respiratory rate, SpO2
- They may not call the nurse for help (Proactive assessment is the key)
Assessment of dyspnea on patients with altered mental status

- Can be challenging to assess dyspnea
- Assume they still suffer from dyspnea
- Pay close attention to facial expressions, labored breathing, RR, SpO2
- Sometimes RR does not go down even after treatments (especially if it’s from metabolic acidosis)
Treatment of dyspnea

Non-Pharmacological Interventions:

- Bring pt upright or to sitting position
- Use oxygen if SpO2 < 90%
  - Nasal cannula Max 5L
  - High flow or BiPAP are not recommended due to production of aerosols

If bronchospasm (wheezing, rhonchi) is noted:

- Use albuterol inhaler with spacer
  - Nebulizer treatments are not recommended due to production of aerosols
- May use steroid with caution
  - The existing literature does not currently provide conclusive evidence for or against the use of steroids
Opioids for dyspnea

- Opioids are the treatment of choice for refractory dyspnea
- Any kinds of opioids work for dyspnea
- Use PRN (q1h) first, then consider to use those medications “around the clock” (q4 to 8h) to prevent undertreatment (dementia or somnolent pt do not ask for PRN)

Dosing Tips:

Opioid naive pt
- PO morphine 5 to 10mg
- PO oxycodone 2.5 to 5mg
- IV/SC morphine 2 to 4mg
If pt is actively dying or under comfort measures, use opioid aggressively and add benzos as needed

Consider using IV/SQ opioids for severe dyspnea
  ○ Quick action and rapid titration
  ○ Continuous infusion

Do not be afraid to use opioids for dyspnea especially if the goal is comfort. Undertreating dyspnea is much worse than the risk of opioid toxicity
  ○ Double effect: If the intention is to provide relief from suffering, some possible toxicity is acceptable

Consult to palliative care specialist if they are available for severe dyspnea
Options of opioid administrations for reducing exposure

May consider starting long-acting opioids in opioid naive patients early to reduce exposure (This is not recommended for non-COVID situation)

Careful assessments of prognosis, goals of care, risk of exposure, PPE availability are crucial

May cause opioid overdose (Consult to palliative care specialist if available)

- **Fentanyl patch 12 mcg/h** (≈ 30 mg/d of PO morphine)
  - Takes at least 12h to reach the full effect -> Use morphine PRN first

- **Morphine SQ/IV infusion at 0.5-1 mg/h** with a loading dose of 1-2 mg
  - With a PCA pump with long tubing, staff may be able to administer PRN bolus from outside the room
Cough

- Codeine: Duration of action is 4 hours; usual adult dose is 10-20 mg every 4-6 hours.
- Dextromethorphan: Duration of action 3-6 hours; usual adult dose is 10-20 mg every 4-6 hours.
- All opioid analgesics have anti-tussive activity
- It is unclear whether adding a second opioid such as codeine for cough is effective
- Nebs are not recommended for COVID-19
- Albuterol inhaler may help
Excess secretions

- Expectorants: Guaifenesin
- Drying agents: Anticholinergic agents such as scopolamine and glycopyrrolate
  - May be very helpful for excessive mucus production
  - Watch for anticholinergic side-effects (dry mouth, urinary retention), or over-drying (may cause mucus plugging)
  - Glycopyrrolate does not reach the brain (i.e. does not cause delirium)
- Bronchodilators: Beta-adrenergic agonists
- Avoid suctioning (May create aerosols. Deep suctioning can be very irritating)
- Terminal secretion: Family education is more important
Acute Pain

- Pain assessment on patients with dementia can be quite challenging
  - Use scales (e.g. PAINAD)
  - Do: Ask about current state and give them the time to respond
  - Don’t: Ask about the past or the time course

- Somnolent patient
  - Use facial expression, body posture, restlessness as indicator
  - Trial of opioid to see if it change the nonverbal clues

- Use acetaminophen first (e.g. 1g q8h PRN)
  - Max dose in geriatric population = 3g per day
  - Avoid NSAIDs in COVID-19

- Use opioids as needed
PAINAD (Pain Assessment In Advanced Dementia) scale

- A useful scale for assessing pain in nonverbal patients with dementia
- Assesses five domains
  - Breathing, negative vocalization, facial expression, body language, and consolability
- Sensitivity 92%, specificity 61%
- Can be used for following up on the effectiveness of treatments

Delirium/restlessness/agitation

1. Full examination:
   a. Look for the source of pain/distress including constipation, urinary retention
   b. Ensure the environment is safe to prevent falls and injuries

2. Non-pharmacological approach
   a. Optimize environments
   b. Review medications
   c. Reduce tethers

3. Pain is the leading cause: Try acetaminophen or one dose of opioids

4. Give halol (e.g. 0.5-1mg PO/SL q1-4h PRN)
   a. May use other atypical antipsychotics

5. Give lorazepam (e.g. 0.5-1mg PO/SL q1-4h PRN)
   a. Works well especially for terminal delirium
Comfort Kit

- Consider prescribing a comfort kit early even if pt is not in hospice
  - Make sure the facility has these medications in stock
  - Especially if the goal is comfort

- Medications:
  - Morphine sulfate solution (20mg/ml)
  - Lorazepam
  - Haldol
  - Glycopyrrolate (or scopolamine, atropine)
GI symptoms: nausea and diarrhea

- Some patients (about 10%) develop GI symptoms

- Nausea
  - Metoclopramide 5-10mg PO q6-8h
  - Ondansetron 4-8mg PO q8h PRN
  - For opioid induced nausea, give either of them 30 min before opioids

- Diarrhea
  - Loperamide 2-4mg PO q4h PRN
Other symptoms

- Fever
  - Use acetaminophen PO/PR
  - Consider around the clock administration

- Opioid-induced constipation
  - If pt is on an opioid, start senna 2T daily. May increase up to 4T BID.
  - Use dulcolax supp and warm water enema as needed
Communication with Family

- **Frequent, regular communication by staff**
  - assign who will call family
- **Expect emotion: Respond with NURSE statements**
- **Explain to them what to expect**
  - i.e. There is a chance of rapid decline
- **Check facility policies on when they can see their loved one (when they are dying)**
- **IDT approach if available**
- **Discussing funeral options can be crucial**
  - Make sure which mortuary can accept COVID patients

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<thead>
<tr>
<th></th>
<th>Example</th>
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<tbody>
<tr>
<td>Naming</td>
<td>“It sounds like you are frustrated”</td>
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<tr>
<td>Understanding</td>
<td>“This helps me understand what you are thinking”</td>
</tr>
<tr>
<td>Respecting</td>
<td>“I can see you have really been trying to follow our instructions”</td>
</tr>
<tr>
<td>Supporting</td>
<td>“I will do my best to make sure you have what you need”</td>
</tr>
<tr>
<td>Exploring</td>
<td>“Could you say more about what you mean when you say that…”</td>
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Lead the way forward

“I am [name], one of the [professionals] on the team.”

“For most people, this is a tough situation.”

“I’m here to walk you through it if you’d like.”

“Here’s what our institution / system / region is doing for patients with this condition.”
(State the part directly relevant to that person.)

Offer the four things that matter to most people

“So we have the opportunity to make this time special.”

“Here are five things you might want to say. Only use the ones that ring true for you.”

“Please forgive me”

“I forgive you”

“Thank you”

“I love you”

“Goodbye”

“Do any of those sound good?”
Validate what they want to say

“I think that is a beautiful thing to say”

“If my [daughter] were saying that to me, I would feel so valued and so touched.”

“I think he/she can hear you even if they can’t say anything back”

“Go ahead, just say one thing at a time. Take your time.”

Expect emotion

“I can see that he/she meant a lot to you.”

“Can you stay on the line a minute? I just want to check on how you’re doing”
Take Home Message

- Acknowledge the uncertainty of the clinical course and prepare for a possible rapid decline
- Clarify the goals of care and provide aggressive symptom managements if the goal is comfort
- Use opioids for dyspnea
- Consider prescribing a comfort kit early
- Communication with family is crucial
Resources

- CAPC: https://www.capc.org/toolkits/covid-19-response-resources/
- Fast Facts: https://www.mypcnnow.org/fast-facts/
- VitalTalk: https://www.vitaltalk.org/
- Kokua Mau: https://kokuamau.org/covid-19-resources/
- PROBARI: Symptom Management Support for COVID-19 in the Nursing Home