Palliative Care and Hospice Medicine

COVID-19 Toolkit

Last Updated: 4/13/20

Updates included in this version:

- COVID-19: Hildebrandt COVID-19 Plan
- Added vitaltalk.org resources
- Added additional communication resources (see bottom of table of contents)

Purpose:

The objective of this toolkit is to provide a resource to:

- Understand the role of palliative care during the COVID19 public health crisis
- Access / consult with the palliative care teams
- Provide education and communication tools for care planning and end-of-life scenarios

Table of Contents:

Additional Resources:

- https://csupalliativecare.org/palliative-care-and-covid-19/
- https://www.capc.org/toolkits/covid-19-response-resources/
- https://www.vitaltalk.org/guides/covid-19-communication-skills/
- https://respectingchoices.org/covid-19-resources/#planning-conversations
- https://act-ur.com/

- Full resources including helpful example videos and supports for PCPs
  https://www.vitaltalk.org/topics/covid-resources/

- Ready playbook for communication (text and sample questions
  https://www.vitaltalk.org/guides/covid-19-communication-skills/

- Short article for PCPs and communication approach in the outpatient arena

Back AIM communication in a

- Communicating a **Positive COVID test** result.

GUIDE-COVID_Wood.pdf

Role of Palliative Care (source: CAPC)

Key Message

The skills that palliative care clinicians use at the bedside—communication, listening to what people are feeling, clear recommendations for treatment, support for priority-setting, and a calm presence—are the same skills that all clinicians need to navigate this crisis.

Talking Points

- Palliative care focuses on improving quality of life for people living with a serious illness, including COVID-19.
- Palliative care specialists' expertise in symptom management and skilled communication is essential to the care of people with COVID-19, including the majority of patients who will survive the disease.
- The palliative care patient population—those living with serious illness—are in the highest risk group for COVID-19, and they and their loved ones are not only particularly vulnerable but also particularly stressed by the current situation.
- Palliative care teams are a scarce resource, however, so it is essential that we deploy our expertise in a manner that reaches the largest numbers of patients in need—including the millions who will survive.
- We therefore urge all palliative care teams to lead their colleagues so that they can rapidly enhance and deploy best practices in communication and symptom management.

Definition of Palliative Care

Palliative care is specialized medical care for people living with a serious illness. This type of care is focused on providing relief from the symptoms and stress of the illness. The goal is to improve quality of life for both the patient and the family.

Resources: https://www.capc.org/toolkits/covid-19-response-resources/

When to Call Palliative Care

Palliative care services can assist when managing health related challenges due to a serious illness. This includes:

COVID-19 Criteria

- Pre-existing palliative care patient
- Symptoms refractory to palliative symptom protocols (Coming Soon)
- On ventilatory support
- Difficult-to-control emotional symptoms
- Patient, family, or physician uncertainty regarding prognosis
- Patient, family, or physician uncertainty regarding non-beneficial treatment options
- Patient or family psychological or spiritual/existential distress
- Patient or family request

General Referral Criteria

Presence of a serious illness and one or more of the following:

- New diagnosis of life-limiting illness for symptom control, patient/family support
- Declining ability to complete activities of daily living
- Weight loss
- Progressive metastatic cancer
- Admission from long-term care facility (nursing home or assisted living)
- Two or more hospitalizations for illness within three months
- Difficult-to-control physical or emotional symptoms
- Patient, family or physician uncertainty regarding prognosis
- Patient, family or physician uncertainty regarding appropriateness of treatment options
- Family request for non-beneficial treatments or therapies
- DNR order conflicts
- Conflicts or uncertainty regarding the use of non-oral feeding/hydration in cognitively impaired, patients over 65, seriously ill, or dying patients
- Limited social support in setting of a serious illness (e.g., homeless, no family or friends, chronic mental illness, overwhelmed family caregivers)
- Patient, family or physician request for information regarding hospice appropriateness
- Patient or family psychological or spiritual/existential distress
- Palliative Performance Scale of 60 or less
- Management of pain and other symptoms including shortness of breath, nausea, anxiety, constipation, depression and fatigue.
- Advanced Care Planning
- Answering questions and providing support to families regarding living with serious illness or end of life care.
- Assistance in navigating complex healthcare issues, including coordination of care with other physicians and services.

How to Reach Us

Inpatient

Palliative Care Consultation Services are available inpatient at Rochester General and Unity hospitals.

ROCHESTER GENERAL HOSPITAL

On-Site Monday – Friday during business hours; Physician on-call by phone 24/7

- To request a consultation enter a Palliative Care Consult Order in Care Connect and call the switchboard (922-4000) to be connected with a Palliative Care team member. In-house M – F Business hours but Physician available 24/7 by phone.

UNITY HOSPITAL

On-Site Monday – Friday during business hours; Provider on-call by pager 24/7

Unity Hospital Palliative Care Team Triage pager: 263-8204 ((Available 24/7)

There has to be a provider-to-provider conversation for a formal consult. We do not receive consults via EMR order.

Outpatient – By Appointment

Phone: 585.922.6772 **Fax**: 585.785.4157

Lipson Cancer Institute
Linden Oaks
20 Hagen Drive, Suite 100
Rochester, NY 14625

Lipson Cancer Institute
Rochester General
1425 Portland Avenue
Rochester, NY 14621

Unity POB
1561 Long Pond Road, Suite 216
Rochester, NY 14626

COVID-19: Hildebrandt COVID-19 Plan

Date: 4/13/2020

Objectives:

- To implement the best strategies for testing and management in anticipation of identifying COVID-19 suspected and confirmed patients at the Hildebrandt Hospice Unit
- To minimize the risk of exposure to Hildebrandt hospice patients, visitors, and staff
- To practice stewardship in the conservation of resources

Features of Hildebrandt Inpatient Hospice Unit:

- Eleven private rooms with private bathrooms: eight acute hospice beds, two acute/residential swing beds and one hospice resident bed
- The layout of the patient's room makes the contact and droplet precautions suboptimal
    - There is no sink near the exit or outside the room: the sink is in the patient's bathroom, which is across the room.
    - Once the provider removes the PPE and washes hands, the provider has to walk across the patient's room to exit the door without PPE.
    - The distance from the entrance to the patient's head of the bed is approximately only 3-4 feet.
- All rooms with in-wall oxygen & suction
- No AIIR room available

Challenges:

- **Unique patient population**
    - Diagnostic workup is not routinely performed in the community hospice setting. Therefore the COVID-19 status is unknown upon admission to the Hildebrandt hospice unit, especially when the patient comes from the community. For public health and mitigation of COVID-19, testing hospice patients may be indicated.
    - The signs and symptoms of end-of-life care may be similar to those for COVID-19 patients. The examples are fever, shortness of breath, cough, pneumonia, etc.
    - The Hildebrandt Inpatient Hospice Unit is for patients with uncontrolled end of life care symptoms. Some of the most common symptoms are severe dyspnea, agitation, and oropharyngeal secretions.
    - It isn't always feasible to mask the COVID-19 suspected or positive patient near the end of life. Typically, patients breathe with open mouth, have a copious amount of secretions which are hard to control (death rattle), and frequently have severe dyspnea and cough. Therefore, the chance of transmission through droplets and possibly aerosols without appropriate PPE is high during the prolonged close face to face contact with the patients with the above symptoms and can't wear a medical mask.
- **Facility capabilities & resources**
    - Inability for optimal droplet precaution and enhanced isolation precaution due to the layout of the room,
        - Location of the sink; it is located in the patient’s bathroom, 4-10 feet away from the door.
        - Inability for social distancing; the proximity of the patient’s head of the bed from the entrance (approximately 3-4 feet)
        - Unsafe to remove PPE inside the room due to the short distance to the patient

- After washing hands in the patient's sink, the staff will have to walk to the exit across the patient without any PPE.
- Ethical obligation to keep the staff and the visitors safe.

- Nursing staffing
  - Primarily RNs and HHAs
  - High RN workload due to significant paper charting
  - Inconsistent staff with per diem RNs
- Oxygen availability for flow rate: no higher than 9 liters per minute
- Medical provider available daily
- PPE
  - Limited supplies of medical masks
  - Limited supplies of reusable gowns
  - Limited supply of disposable gowns
  - Ethical obligation to provide staff caring for COVID-19 patients the same PPE for the same patients & procedures regardless of the setting
  - Ethical obligation to keep the visitors safe

- **Lack of inpatient hospice specific guidance from CMS and NYSDOH**
  - Transfer recommendations
  - Admission restrictions
  - Testing recommendations
  - Similar clinical pictures between highly febrile death and COVID-19 infection

Scenario:

Scenario 1: Confirmed or COVID-19 suspected during the HIPU stay

- Place enhanced isolation signage on the door, close the door and restrict visitors.
- Place a dirty gown hamper and trash can inside the room, close to the door.
- Place a trash can outside the door.
- Place an isolation cart outside the door.
- Place the PPE educational signage on the door
- Call RRH infection prevention, medical provider and Lifetime care leadership
- Use HEPA filtration in rooms of COVID-19 positive patients requiring aerosol-generating procedures.
- Maintain staffing levels. Scheduling to ensure the staff who were caring for the patient are consistently assigned to this same patient assignment/team for patient care as much as possible.
- The patient's head of the bed is within 6 feet from the door. Keep the door closed all the time. Limit the entry to the minimum. Keep the interaction brief with appropriate PPE.
- Follow the donning and doffing sequence.
- Hands will be cleaned with a hand sanitizer outside the room. Staff will proceed to the visitor's bathroom and wash hands with soap and water for 20 seconds
- Bundle care to minimize the number of times staff need to enter the room

- Utilize communication methods and limit the staff who do not need to go into the room. Further limit ancillary staff exposure and potential transmission.

- Identify who is the back up if the initial staff assigned to care becomes ill.

- N95-use protocol to be educated to staff who would provide this treatment. Restrict HHAs and other staff from entering the room while doing aerosolizing procedures (nebulizer treatment, high flow o2, BIPAP manipulation, CPAP manipulation, chest physiotherapy, etc.)
- Place the medical mask on the patients who have death rattle, agonal mouth breathing, and oropharyngeal secretions if feasible. It is acknowledged that it is not feasible to mask the patient when actively dying or highly symptomatic.
- When COVID-19 positive or the suspected patient has death rattle, agonal breathing, oropharyngeal secretions with open mouth and can't wear a medical mask, there is a risk of droplet and possibly an aerosol transmission. Any staff with prolonged close face to face contact would need an N95 mask in this case.
- If there are more than one COVID-19 patient, make an effort to keep them in the same wing if feasible
- If the patient becomes COVID-suspected based on clinical assessment, pursuing the test may be necessary as it affects staffing, visitors, and PPE resources.

Scenario 2: Contact of the COVID-19 patient (Patient is notified to be the close contact of the COVID-19 case while in HIPU)

- Place the patient on droplet and contact precaution.
- Determine if the testing will change the management, staffing, and PPE resources.
- Place a hamper, hand sanitizer, trash can, paper towel inside the door.
- Place a trash can outside the door.
- Place an isolation cart outside the door. Place hand sanitizer, paper towel on the cart.
- Place the PPE educational signage on the door
- Call RRH infection prevention, medical provider and Lifetime care leadership
- The patient's head of the bed is within 6 feet from the door. Keep the door closed all the time. Limit the entry to the minimum. Keep the interaction brief with appropriate PPE.
- Follow the donning and doffing sequence.
- Hands will be cleaned with a hand sanitizer outside the room. Staff will proceed to the visitor bathroom and wash hands with soap and water for 20 seconds
- Bundle care to minimize the number of times staff need to enter the room
- Utilize communication methods and limit the staff who do not need to go into the room. Further limit ancillary staff exposure and potential transmission.
- Identify who is back up if the initial staff assigned to care becomes ill.
- Place the medical mask on the patients who have death rattle, agonal breathing, and oropharyngeal secretions with open mouth.
- They are monitored each shift for respiratory symptoms and fever.

Scenario 3: Admitting known or suspected COVID-19 patients

- Case manager or Liaison speak with the medical provider on call. Medical provider may call the attending for warm hand off
- Ambulance is noted that the patient is covid-19 positive or suspected
- Place enhanced isolation signage on the door, close the door and restrict visitors.
- Place a dirty gown hamper and trash can inside the room, close to the door.
- Place a trash can and an isolation cart outside the door.

- Place the PPE educational signage on the door
- Follow the donning and doffing sequence.
- Hands will be cleaned with a hand sanitizer outside the room. Staff will proceed to the visitor bathroom and wash hands with soap and water for 20 seconds
- Bundle care to minimize the number of times staff need to enter the room
- Utilize communication methods and limit the staff who do not need to go into the room. Further limit ancillary staff exposure and potential transmission.
- Identify who is back up if the initial staff assigned to care becomes ill.
- Place the medical mask on the patients who have death rattle, agonal breathing, and oropharyngeal secretions with open mouth.

Testing Strategies:

Testing Strategy 1: Test in Place (patient remains in the current room)

- **Advantages:** Knowing the result may avoid unnecessary visitor restriction and affect the post mortem care. The negative test result will save PPE. It will affect staffing and PPE resources.
- **Disadvantages:** Getting the test kit is not always possible. Currently, obtaining an NP swab is done by a medical provider only with full PPE. Once obtained, personnel has to leave the unit to drop off the specimen.
- **Procedure**:
  - Follow the scenario 1.
  - With facility leadership, notify RRH Infection Prevention, contact NYSDOH.

Testing strategy 2: No test, assume the patient has COVID-19.

- **Advantages:** Getting the patient tested is not an easy task. Not getting the patient tested will save the administrative time to make arrangement, especially when the prognosis is very short.
- **Disadvantages: Knowing the result** may not change the management of the patient but assuming the patient to be infected will increase the burden of staffing, may cause the overuse of PPE, and may unnecessarily restrict the visitors. Assuming the patient has COVID will restrict visitors and affect the post mortem care.
- **Procedure**: follow scenario 1 as above.

Management Strategies:

- Place the patient on enhanced isolation
- Closely monitor PPE and staffing
- Inform the family of the COVID status and educate about the risk of COVID infection so that they can make an informed decision about visiting the pt.
- Inform the funeral home of the COVID status

Conclusion:

1. The Hildebrandt Inpatient Hospice Unit is responding to COVID-19 pandemic and managing COVID suspected or confirmed patients.
2. When COVID-19 positive or the suspected patient is actively dying and has death rattle, agonal breathing, oropharyngeal secretions with open mouth, and can't wear a medical mask, there is a risk of the droplet and possibly an aerosol transmission. Typically the direct care of the patient is performed with one RN and one HHA. Any staff with prolonged close face to face contact needs an N95 mask in this case.
3. Hildebrandt needs portable HEPA filters for COVID rooms, as we do not have any AIIR room. They have been ordered, and the delivery is expected to be weeks away. The aerosol-generating procedure will be avoided until the HEPA filtration is in place.
4. It will be a challenge for visitors to don and doff PPE for enhanced isolation precaution. Visitors need education and may need supervision from the staff.
5. Following the NYSDOH guideline, we have visitor restrictions in place. We are aware that it is a challenge for family members. Given the limited amount of PPE and the risk of infection, visitors are educated about the visitor restriction, and we will continue to guide them to make an informed decision.

References:

- https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html
- https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/guidance-hcf.html
- https://commerce.health.state.ny.us/HCSRestServices/HCSContentServices/docs?docPath=/hcs_Documents/Source/hpn/hpnSrc/A0FE8C6480C21018E0530547A8C0F8E2.pdf
- https://www.cms.gov/files/document/qso-20-16-hospice.pdfhttps://www.cms.gov/files/document/qso-20-16-hospice.pdf
- Healthcare Preparedness for SARS-Cov2 and COVID-19. Terri Rebmann, PhD, RN, CIC, FAPIC, Association for professionals on Infection control and Epidemiology. March 17th, 2020
- https://commerce.health.state.ny.us/hcs/index.html, DOH_COVID19_Hospital Visitation_041020_1586551162982_0.pdf

Telemedicine and Palliative Care

Outpatient

Similar to other outpatient clinics, Palliative Care will be utilizing telephone and telemedicine visits whenever possible to support social distancing. The attending provider will determine if the visit can be completed via telephone / telemedicine.

Outpatient is by appointment, please refer patients by calling

Phone: 585.922.6772 Fax: 585.785.4157

Inpatient

Due to visitor restrictions and the contagious nature of COVID-19, many patients are faced with goals of care decisions and end of life situations alone. In order to support a safe experience for the patient's family / loved ones, the RGH and Unity inpatient palliative teams are in the process of purchasing iPads that will be able to support virtual face-to-face meetings and experiences with visitors. This toolkit will be updated with the protocol and guidelines to use this technology once the iPads are acquired and programmed.

Ventilator Withdrawal: Symptom Management Guidelines

Adult Medication Protocol:

1.) Discontinue paralytics. Allow time for existing paralytic medication to be metabolized. Paralytic agents do not have a role in ventilator withdrawal.
2.) Before ventilator withdrawal, give the following:
    a. 2-10 mg bolus of Morphine IV or equivalent, followed by an infusion of 1-5 mg/hr IV.
    b. 1-2 mg bolus of Midazolam IV, followed by an infusion of 1 mg/hr IV.
    c. If the patient is already on continuous opioids or anxiolytics, increase the infusion by 30%, and give 10% of the 24 hour dose as a bolus.
3.) Titrate these medications to control labored respirations, restlessness, minimize anxiety, and to achieve adequate level of comfort and sedation prior to extubation.
4.) Have additional medication drawn up and ready to rapidly administer at the bedside if needed.
5.) If distress ensues after ventilator withdrawal, use additional sedating medication (i.e. Morphine 5-10 mg IV q10min and/or Midazolam 2-4 mg IV q10 min) until distress is relieved. Adjust both infusion rates upward by 30% until distress is relieved.
6.) Specific dosages are less important than the goal of symptom relief. A goal should be to keep the respiratory rate < 20-30, HR < 80-100 bpm, and eliminate grimacing and agitation.
7.) For symptoms refractory to the above treatments, can add Propofol.

Regimen A: Morphine plus Midazolam (Adult doses)	Good for comatose patients or patients with limited consciousness and/or patients with little prior exposure to these drugs.	**Bolus**: Morphine 2-10 mg IV; Midazolam 1-2 mg IV	**Infusion**: Morphine 1-5 mg/hr; Midazolam 1 mg/hr
Regimen B: Propofol (Adult doses)	Good for the awake patient who can be expected to have demonstrable respiratory distress following ventilator withdrawal.	**Bolus**: Propofol 20-50 mg IV	**Infusion**: Propofol 10-100 mg/hr

Symptom Medications: Rescue Medications for Symptom Distress & Symptom Control (Source: CAPC)

Rescue Medications for Symptom Distress

Rescue medications are for symptoms that are unrelieved by regularly administered medications. Once acute symptoms are controlled, switch to standing (around the clock) regimen of the effective dosage, every 4 hours for morphine, every 6 hours for haloperidol, lorazepam, and metoclopramide. For more opioid prescribing guidance, see pain card.

Pain or Shortness of Breath or Cough:

ORAL or SUBLINGUAL:
Morphine liquid: 10 mg per 5 ml, take 2.5 ml every 30 minutes until relief. Increase to 5 ml if no relief from starting dosage.

Morphine tablets 15mg: ½ tablet PO every 30 minutes until relief. Increase to 1 tablet if no relief from starting dosage.

IV or SQ:
Morphine 5mg IV or SQ every 30 minutes until relief. Increase to 10 mg if no relief from starting dosage.

Nausea, Restlessness, Anxiety, Agitation, or Confusion:

ORAL or SUBLINGUAL:
Haloperidol liquid (Haldol): 2 mg per ml, Give ¼ ml to ½ ml by mouth or under tongue every hour until relief or calm.
Haloperidol tablets: 1 mg tablet, give half tablet every 1 hour until calm, increase to full tablet if no relief from starting dosage.

IV or SQ:
Haloperidol 2 mg/ml ¼ ml every hour until relief, increase to ½ ml if no relief from starting dosage.

Anxiety, Restlessness, or Agitation (not relieved by haloperidol):

ORAL or SUBLINGUAL:
Lorazepam liquid (Ativan): 2 mg per ml, Give ¼ to ½ ml by mouth or under tongue every hour until relaxed/calm, increase to 1ml if no relief from starting dosage.
Lorazepam tablets: 1 mg tablet, give ½ tablet every hour until calm, increase to 1 tablet if no relief.

IV or SQ:
Lorazepam 1 mg/ml, give ½ ml every hour until relief, increase to 1 ml if no relief from starting dose.

Symptom Control

Pain, dyspnea, cough:

ORAL or SL:
Morphine Sulfate: 15 mg ½-1 tablet every 4 hours AROUND THE CLOCK. (once we know what the average daily total requirement is to keep pain or dyspnea below a 5 out of 10, switch to a long acting pain medicine, see pain card).

IV or SQ:
Morphine 5 mg IV or SQ every 3 hours around the clock. Increase by 50% for pain unrelieved by starting dose.

Nausea:

ORAL or SUBLINGUAL:
Metoclopramide: 10 mg every 6 hours around the clock.
OR
Ondansetron: 4 mg every 8 hours, increase to 8 mg if no relief from starting dosage.

IV or SQ:
Metoclopramide 5 mg/ml, give 1 ml every 6 hours around the clock.
OR
Ondansetron: 0.15 mg/kg IV every 8 hours

****If using antiemetics for opioid-induced nausea give 30 minutes before morphine to prevent nausea - this should only be necessary for 3-4 days as nausea wears off with time.**

Preventing Constipation:

Miralax powder: 1-2 capfuls in water or juice or any liquid you like *every day*. If no daily bowel movement increase to 3 capfuls. Over the counter.
+
Dulcolax suppository: 1 or 2 per rectum *every morning* after breakfast. Over the counter.

Stepwise Protocols for Crisis Symptom Management (Source: CAPC)

Dyspnea/Cough Protocol

Step 1: Optimize underlying disease treatment

If no relief then…

Step 2: Check oxygen saturation – supplement if below 90%

If no relief then…

Step 3: Start opioid**

ORAL or SL: Morphine Sulfate: 15 mg ½-1 tablet every 4 hours AROUND THE CLOCK.

IV or SQ: Morphine 5 mg IV or SQ every 3 hours around the clock. Increase by 50% for pain unrelieved by starting dose.

****Introduce laxative if prescribing opioid: see constipation protocol**

If no relief then…

Step 4: Referral to Palliative Care 2

Acute Pain Protocol

Step 1: Non-opioid pharmacological therapy

Acetaminophen 500mg by mouth every 6 hours prn (avoid in liver disease)

****NSAIDS contraindicated in COVID19:** **https://www.bmj.com/content/368/bmj.m1086**

If acetaminophen not effective…

Step 2: Start opioid

ORAL or SUBLINGUAL: Morphine Sulfate: 15 mg ½-1 tablet every 4 hours AROUND THE CLOCK (once we know what the average daily total requirement is to keep pain or dyspnea below a 5 out of 10, switch to a long-acting pain medicine).

IV or SQ: Morphine 5 mg IV or SQ every 3 hours around the clock.

****Increase by 50% for pain unrelieved by starting dose.**
****Introduce laxative if prescribing opioid: see constipation protocol**

If not effective…

Step 3: Referral to Palliative Care 3

Agitation/Delirium/Restlessness/Confusion Protocol

Step 1: Full examination - look for sources of pain/distress including constipation, urinary retention, pressure ulcers

Step 2: Review medication list and delete all non-essential medication to reduce anticholinergic burden: American Geriatrics Society 2019 Updated AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults

Step 3: Pain is a leading cause of delirium - Try non-opioid pharmacological therapy
Acetaminophen 500mg by mouth every 6 hours prn (avoid in liver disease)

****NSAIDS contraindicated in COVID19:** **https://www.bmj.com/content/368/bmj.m1086**

If acetaminophen not effective…

Step 4: Start opioid

ORAL or SL: Morphine Sulfate: 15 mg ½-1 tablet every 4 hours AROUND THE CLOCK.

IV or SQ: Morphine 5 mg IV or SQ every 3 hours around the clock.

****Increase by 50% for pain unrelieved by starting dose.**
****Introduce laxative if prescribing opioid: see constipation protocol**

If not effective…

Step 5: Haloperidol (Haldol)

ORAL or SUBLINGUAL:
Haloperidol liquid (Haldol): 2 mg per ml, Give ¼ ml to ½ ml by mouth or under tongue every hour until relief or calm.
Haloperidol tablets: 1 mg tablet, give half tablet every 1 hour until calm, increase to full tablet if no relief from starting dosage.

IV or SQ:
Haloperidol 2 mg/ml ¼ ml every hour until relief, increase to ½ ml if no relief from starting dosage.

If haloperidol not effective…

Step 6: Lorazepam

ORAL or SUB LINGUAL:
Lorazepam liquid (Ativan): 2 mg per ml, give ¼ to ½ ml by mouth or under tongue every hour until relaxed/calm. Increase to 1ml if no relief from starting dosage.
Lorazepam tablets: 1 mg tablet, give ½ tablet every hour until calm, increase to 1 tablet if no relief.

IV or SQ:
Lorazepam 1 mg/ml, give ½ ml every hour until relief, increase to 1 ml if no relief from starting dose.
If lorazepam not effective…

Step 7: Referral to Palliative Care 5

Nausea and Vomiting Protocol

Step 1: Reverse underlying cause if possible (GI obstruction, vertigo, constipation)

Step 2: Treat empirically with metaclopramide (Reglan) or ondansetron (Zofran)

ORAL or SUBLINGUAL:
Metoclopramide: 10 mg every 6 hours around the clock
OR
Ondansetron: 4 mg every 8 hours, increase to 8 mg if no relief from starting dosage

IV or SQ:
Metoclopramide: 5 mg/ml, give 1 ml every 6 hours around the clock.
OR
Ondansetron: 0.15 mg/kg IV every 8 hours

****If using either drug for opioid-induced nausea, give 30 minutes before morphine to prevent nausea - this should only be necessary for 3-4 days as nausea wears off with time.**

If not effective…

Step 3: Haloperidol (Haldol)

ORAL or SUBLINGUAL:
Haloperidol liquid (Haldol): 2 mg/mL, give ¼ to ½ ml by mouth or under tongue every hour until calm.
Haloperidol tablets: 1 mg tablet, give 1/2 tablet every hour until calm, increase to full tablet if no relief.

IV or SQ:
Haloperidol: 2 mg/ml ¼ ml every hour until relief, increase to ½ ml if no relief from starting dosage.

If not effective…

Step 4: Lorazepam

ORAL or SUB LINGUAL:
Lorazepam liquid (Ativan): 2 mg per ml, give ¼ to ½ ml by mouth or under tongue every hour until relaxed/calm, increase to 1ml if no relief from starting dosage.
Lorazepam tablets: 1 mg tablet, give ½ tablet every hour until calm, increase to 1 tablet if no relief.

IV or SQ:
Lorazepam: 1 mg/ml, give ½ ml every hour until relief, increase to 1 ml if no relief from starting dose.

If not effective…

Step 5: Referral to Palliative Care 6

Constipation Protocol

Step 1: Rule out impaction/obstruction

Step 2: Add polyethylene glycol (Miralax) powder: 1-2 capfuls in water or juice or any liquid you like *every day*. If no daily bowel movement increase to 3 capfuls, in divided doses. Over the counter.

If not effective after 48 hours…

Step 3: Dulcolax suppository: 1 or 2 per rectum *every morning* after breakfast. Over the counter.

If not effective after 48 hours…

Step 4: Enema - warm tap water, repeat until results (DO NOT use Fleets because of risk of hyperphosphatemia, hypocalcemia, arrhythmia).
If no effect…

Step 5: Referral to Palliative Care

How to have conversations about goals and life supports with patients and families

1. **Palliative Care Consults**: Please consider a consult for any patient over 50 with a full code status and significant comorbidities AND any patient over 75 with a full code status or DNR with vent. Our job is to work with patients and their families to make sure their wishes are carried out during this crisis. We will work to align their goals with the medical plan and also develop a therapeutic, trusting relationship with families throughout the course of an admission.

2. **GOALS discussion**: Recall that many (especially older) patients would either like limits in place (but have never had the discussion with their providers) OR were planning to put limits in place when a life threatening situation arose. It is especially important to think PROACTIVELY when discussing because we need to eliminate emergent intubations as much as possible and focus on elective intubations for the safety of ALL the hospital staff as well as patients.

3. **Language Tips:**

AVOID:	INSTEAD USE:
• **Its time to…**	
"give up"	**"refocus our efforts on comfort"**
• **We don't think this procedure will…**	
"help"	**"offer any benefit and increase suffering."**
• **Let's talk about…**	
"hospice care"	**"a comfort focused approach so your loved one is not suffering"**

4. **STRUCTURING A GOALS DISCUSSION**: After giving an honest medical update focus on the **GOOD** model as below:

G: Goals: What are your goals for your loved one at this time, knowing the facts we have discussed? What is most important to you and your loved one at this time?
O: OPTIONS: Here are the options before us 1. Continue all artificial supports. 2. Limit the most aggressive artificial supports which do not offer benefit but continue doing interventions that may be beneficial. 3. Refocus our efforts on comfort so that your loved one is not suffering. (TIP: say to families: *"Try to imagine your loved one joining in on this conversation,. What would he/she ask us to do?"*)
O: OPINION: here is where, if asked, you can give your honest thoughts taking into consideration the goals of care you have learned at the beginning of the discussion, such as "I don't want him/her to suffer".
D: Decision: Either – 1. Make a change to the MOLST or code status, ie DNR with vent, DNR/DNI. Comfort care, full code with trial of ventilator. 2. If a trial of full support is continued, make a clear plan for when to reassess and have this discussion again. (ie a Day, 2 days, later this afternoon, whatever seems appropriate, and stick to it.)

In general, our experience as Palliative Care providers is that *MOST patients and families will work thoughtfully through these steps and decisions.* They may require a few discussions to proceed through placing limits but will feel **empowered** and that we dealt with them **collaboratively** in this process. The earlier we start this process the better.

VitalTalk: Resourcing – When limitations force you to choose, and even ration

The skills that palliative care clinicians use at the bedside—communication, listening to what people are feeling, clear recommendations for treatment, support for priority-setting, and a calm presence—are the same skills that all clinicians need to navigate this crisis.

Resourcing *When limitations force you to choose, and even ration*

What they say	What you say, and why
Why can't my 90 year old grandmother go to the ICU?	***This is an extraordinary time. We are trying to use resources in a way that is fair for everyone.*** Your grandmother's situation does not meet the criteria for the ICU today. I wish things were different.
Shouldn't I be in an intensive care unit?	Your situation does not meet criteria for the ICU right now. The hospital is using special rules about the ICU because we are trying to use our resources in a way that is fair for everyone. ***If this were a year ago, we might be making a different decision. This is an extraordinary time.*** I wish I had more resources.
My grandmother needs the ICU! Or she is going to die!	I know this is a scary situation, and I am worried for your grandmother myself. ***This virus is so deadly that even if we could transfer her to the ICU, I am not sure she would make it.*** So we need to be prepared that she could die. We will do everything we can for her.
Are you just discriminating against her because she is old?	I can see how it might seem like that. No, we are not discriminating. ***We are using guidelines that were developed by people in this community to prepare for an event like this***. The guidelines have been developed over the years, involving health care professionals, ethicists, and lay people to consider all the pros and cons. I can see that you really care about her.
You're treating us differently because of the color of our skin.	***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, and I wish things had been different. 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. I do not want people to be treated by the color of their skin either.
It sounds like you are rationing.	What we are doing is trying to spread out our resources in the best way possible. ***This is a time where I wish we had more for every single person in this hospital.***
You're playing God. You can't do that.	I am sorry. I did not mean to give you that feeling. ***Across the city, every hospital is working together to try to use resources in a way that is fair for everyone. I realize that we don't have enough.*** I wish we had more. Please understand that we are all working as hard as possible.
Can't you get 15 more ventilators from somewhere else?	Right now the hospital is operating over capacity. It is not possible for us to increase our capacity like that overnight. And ***I realize that must be disappointing to hear.***
How can you just take them off a ventilator when their life depends on it?	I'm so sorry that her condition has gotten worse, even though we are doing everything. Because we are in an extraordinary time, we are following special guidelines that apply to everyone here. We cannot continue to provide critical care to patients who are not getting better. This means that we need to accept that she will die, and that we need to take her off the ventilator. I wish things were different.

Introducing and Scheduling Proactive Care Planning for COVID-19

What matters most to youmatters tous

Note to User: This guide is **for use by team member to invite and schedule the healthcare agents or dedicated decision makers of individuals at greatest risk for complications from COVID-19**, to have a proactive conversation about their preferences for care.

1. **The invitation** (virtual or in person)

   "It is important that the healthcare team understands what matters most to **[name of individual]** *in the event that* **[name of individual]** *becomes seriously ill as a result of COVID-19. We are eager to make sure we understand what they would want."*

   "As the healthcare agent/DDM for **[name of individual]** ***your role is to help the healthcare team:***

   – Follow **[name of individual's]** *previous decisions.*

   – Make decisions in difficult moments (e.g., stressful times, differing opinions; crisis situations) that are in line with **[name of individual's]** *goals, values, and preferences."*

2. **Provide the context for having further conversation**

   "There's no way to tell if a sudden illness, such as COVID-19, could leave **[name of individual]** *seriously ill and you, as their healthcare agent/DDM, may need to make decisions about treatment options and where* **[name of individual]** *might receive care, such as staying at home, hospital, or care facility. By giving direction ahead of time, the doctors will know what matters most to* **[name of individual]**, *and treatments that match* **[name of individual's]** *goals and values."*

   "Has **[name of individual]** *completed a POLST form?"*

   - **If yes:** *"It is important to review this document with the care team now to understand what matters most in the event* **[name of individual]** *becomes seriously ill." Proceed to #3: Make recommendations to continue the conversation.*
   - **If no:** *"We are here to help you have a conversation with the care team, so they know your answers to questions such as:*
     - *What is most important for* **[name of individual]** *to live well? For example, if they were having a good day, what would happen on that day?*
     - *What personal, cultural, or spiritual beliefs does* **[name of individual]** *have, if any, that would impact their care?*
     - *What would* **[name of individual]** *want if they became very ill? For example, would they want their medical care to focus on living longer, maintaining current health, or comfort care?*
     - *Anything else you would want us to know about what is important to* **[name of individual]** *at this time?"*

3. **Make recommendations to continue the conversation**

   "Thank you for taking the time to talk with me today. Let's talk about next steps. Can I schedule a time for you to talk with a clinician and continue the conversation, to make sure the care team is sure to know and honor **[name of individual's]** *preferences for care?"*

   "What questions do you have? Thank you again for talking with me today."

Note to User: Make an appointment (telephonic, telemedicine, video conference, or in-person, as appropriate) to talk with a clinician (e.g., Facilitator, nurse, social worker, chaplain, physician, advanced practitioner) to continue the conversation.

- **Explore meaning of words/phrases**
  "What does, 'I feel like a burden' mean to you?"
- **Paraphrase/clarify**
  "You were frustrated being in the hospital; tell me more."
- **Ask, "Anything else?"**
  "You have said you are weak, tired, and frustrated. Anything else?"
- **Listen for and summarize themes**
  "You have talked about how difficult it was making decisions when your father was seriously ill. This conversation can help better prepare your family."
- **Affirm/reaffirm purpose of conversation**
  "You say this conversation is hard for you. I hope to help you today, to make it easier to learn how to talk to each other."
- **Verbalize empathy**
  "I'm sorry to hear you lost your job. I see that this is very upsetting."

(over)

- **Use the Ask-Teach-Ask technique**
  When providing information:
  1. First, ASK... what the individual understands.
  2. Then, TEACH...provide information to fill in gaps in understanding.
  3. Last, ASK (i.e., Teach-Back)...assess understanding of information before moving on.

  "These are new ideas for many people, so I want to make sure I was clear. Can you tell me what you now understand about _____?"
- **Remain value-neutral**
  Avoid words, phrases, or nonverbal expressions that may communicate personal biases or values.
- **Pay attention to nonverbal communication**
  (facial expressions, body movements)

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