County of Los Angeles **Department of Health Services**

HARBOR-UCLA MEDICAL CENTER

TITLE: **Emergency Department Expected Practice for Goals of Care Discussions, Palliation, and Considerations of Medical Futility in Patients with SARS-CoV-2/COVID-19 infection**

PURPOSE: To provide guidance for emergency physicians and healthcare providers in the emergency department evaluating and treating patients with acute respiratory distress due to SARS-CoV-2/COVID-19 infection

DEPARTMENTS: Department of Emergency Medicine (DEM)
Department of Medicine
Department of Nursing

DATE OF REVIEW: **April 14, 2020**

The purpose of this expected practice is to provide guidance for emergency physicians and healthcare providers in the emergency department who are evaluating and treating patients who present with or develop acute respiratory distress from SARS-CoV-2/COVID-19 infection. While acknowledging that emerging evidence is sparse and unvalidated, we believe these recommendations represent the best of what is currently known and balance an expeditious use of resources, minimizing unnecessary exposure for healthcare workers, maintaining a safe environment of care, and prioritizing treatment priorities most likely to be efficacious.

These guidelines do not apply to disaster situations when a crisis standard of care would apply.

Expected Practice:

1. Goals of care discussions should be considered in all patients presenting with possible or suspected SARS-CoV-2/COVID-19 infection **before** they develop respiratory distress (see appendix 1 for discussion tools) and a decision maker should be identified as soon as possible
    a. The decision maker may be identified by the nursing staff, physicians, or social worker and can be done on arrival, which may be especially important as family members are asked to remain outside to minimize possible exposure to SARS-CoV-2/COVID-19
    b. The decision maker should be documented on the “Surrogate Decision Maker” ad hoc form available in Cerner, noted in the clinician’s note, and communicated at hand-off.
2. Decision aids in the patient’s native language should be used whenever possible (see appendix 2)

3. Intubation should only be considered after careful thought for medical futility in patients with SARS-CoV-2/COVID-19 infection if any of following conditions are met:
    a. Age $\geq$ 85 and living in a skilled nursing facility
    b. Bedbound with poor baseline functional state
    c. Non-verbal due to advanced dementia
    d. Underlying terminal illness
        i. Advanced malignancy
        ii. Severe heart disease, or lung disease requiring home O2
        iii. End-stage liver disease or decompensated cirrhosis
    e. SOFA Score >11 or develops cardiac arrest[1]
4. It is appropriate and preferred to recommend comfort measures rather than intubation for these patients in whom survival and return of functional status after prolonged intubation is unlikely as listed above (see appendix 3 for suggested measures).
5. Palliative Care consult should be considered in patients for whom medical futility is likely and/or further assistance is needed with goals of care discussion, patient/family support, and/or symptom management.
    a. For patients $\geq$ 65 years old, consider consulting geriatrics to assist in goals of care discussion
    b. If goals are clear that a patient is electing hospice or comfort-focused care and symptoms are managed, palliative care consult is not required
6. Home health referral should be considered to assist with home hospice disposition as soon as possible
7. Social work consultation may be obtained to assist in home or skilled nursing facility hospice when appropriate

Reviewers

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[1] Schneider S. Ventilators. *ACEP COVID-19 Field Guide.* www.acep.org/corona/covid-19-field-guide/treatment/ventilator-allocation/

Appendix 1 – Tools for goals of care discussions

Figure 5: Approaching goals of care conversations systematically as a procedure:

The Five Minute ED Goals of Care Procedure	
Minute 1-2	- Elicit patient/surrogate understanding of underlying illness and today's acute change - If available, build off previous advance directives or documented conversations - Acquire sense of patient's values and character (to help frame prognosis and priorities for intervention) - Name and validate observed goals, hopes, fears, and expectations
Minute 3-4	- Discuss treatment options using reflected language - Continually re-center on patient's (not family's) wishes and values - Recommend a course of action, avoiding impartiality when prognosis is dire
Minute 5	- Summarize and discuss next steps - Introduce appropriate ancillary ED resources (e.g., hospice/observation unit, social work, chaplain)

Table 1. Word choice matters in goals of care conversations [adapted from Wang][1]

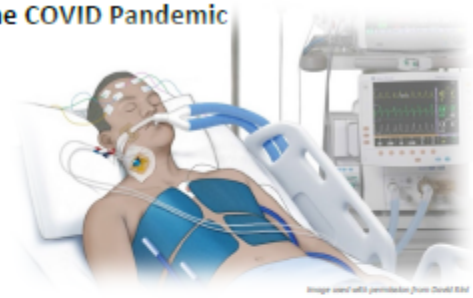
Avoid these phrases	Use these phrases
We need to discuss code status. I wouldn't want this for my own mother.	Tell me about your mother. What was she like before she became ill? How has this illness affected her quality of life?
I don't believe resuscitation would be successful. It is highly unlikely that she would ever get off these life support machines.	It seems like this illness has already taken many of her joys away from her. From what I see today, I do not think she would be able to return to that quality of life that is meaningful to her, not even to her current state. This is the natural course of her disease, and she is now dying.
Do you want us to do everything? Would she want heroic measures? Do you want us to push on her chest or put in a breathing tube?	Based on what you have told me about your mother, do you think she would want to die a natural death?
There is nothing more we can do.	I wish things were different. I suggest that we shift our focus now to keeping her comfortable, and aggressively use medications to reduce any distress she may feel.

[1] Wang DH. "Beyond Code Status: Palliative Care Begins in the Emergency Department." Annals of Emergency Medicine 2017;69(4): 437-443.

Appendix 2 – sample Decision Aid

Life Support During the COVID Pandemic

This is an unusual time, with very large numbers of very sick people right now. Some people are getting so sick that they need a life support machine (like a ventilator or breathing machine – see picture).



Because of the current pandemic, there might not be enough life support machines for everyone who needs them. Hopefully, this does not happen.

In this very difficult time, it's really important to be clear about your values and main concerns for your health care.

How would decisions about who gets a life support machine be made?

If there is a shortage, a team of doctors and nurses will review all cases of patients who need life support machines. This team will make tough decisions based on the best medical information available. The team will not be given information about patient race, ethnicity, religion, insurance or other unrelated things.

What are my choices?

You may not have a choice. But this is an important time to think about what you would want. People often have thoughts about life support machines.

- Some people say, *"I would like to have a life support machine if there is one."*
- Others may say, *"I want a life support machine if there is one, but first think of others who may be more likely to survive."*
- A third group of people may say, *"I do not want any kind of life support or breathing machine. If it comes to that, please let me have a natural death."*

For people who do not get life support machines, care and treatment will focus on the relief of pain and suffering. The goal is to make sure patients are comfortable.
Your health care team and your loved ones need to know what you want if you need a life support machine.

If you become sick enough to need a life support machine, what would you want?

- ☐ I want to be on a life support machine, if a machine is available.
- ☐ I want one if it is available, but first consider others who may be more likely to survive. I understand this would mean that I am more likely to die.
- ☐ I don't want one, even if it is available. I understand this would mean that I am more likely to die.

Are you sure that your answer above says what you really want?

- ☐ Yes, I understand and my answer above says what I really want.
- ☐ No, I need to ask questions and talk to a doctor and my loved ones before I can be sure.

What are the next steps?

Even if you do not know the answers to the above questions right now, you should do one very important thing:

- Name a medical power of attorney:
  - The medical power of attorney is the person who speaks for you if you can't speak for yourself.
  - If you already have one, please give a copy of that document to your health care team.
  - If we do not have it in your records, complete a medical power of attorney document now.
- Talk to this person so they know what is truly important to you. **This is the most important step.**

This is a hard time for everyone. We're all working together. Please continue this conversation with your medical team with any questions you may have.

Information on the development of this document can be found at www.patientdecisionaid.org

Appendix 3

Stepwise Protocols for Symptom Management:

Dyspnea/Cough
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 (**Introduce laxative: see constipation protocol).** If no relief then…
Step 4: Referral to Palliative Care

Acute Pain
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
Step 3: Referral to Palliative Care

Agitation/Restlessness/Confusion
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 (see Acute Pain protocol). If not effective then…
Step 4: Haloperidol (Haldol). If not effective then…
Step 5: Lorazepam. If not effective then…
Step 6: Referral to Palliative Care

Nausea/Vomiting
Step 1: Reverse underlying cause if possible (GI obstruction, vertigo, constipation, medication)
Step 2: Treat empirically with metoclopramide (Reglan) or ondansetron (Zofran). If not effective then…
Step 3: Haloperidol (Haldol). If not effective then…
Step 4: Lorazepam. If not effective then…
Step 5: Referral to Palliative Care

Constipation
Step 1: Rule out impaction/obstruction
Step 2: Start Senna 2 tabs or polyethylene glycol (Miralax) powder: 17g in any liquid *every day*. If no daily bowel movement, can increase up to 3 times daily Miralax or 2 tabs Senna twice daily. If not effective after 48 hours…
Step 3: Dulcolax suppository: 1 or 2 per rectum *every morning* after breakfast. 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

Rescue Medications for Symptom Distress

COVID-19 Clinical Resource

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

Drug	Indication	Route	Starting Dose	Starting Frequency
Haloperidol	Restlessness Anxiety Agitation Confusion Nausea/Vomiting	Oral Sublingual IV	0.5 mg	Every 1 hour until calm. Increase to 1 mg if no relief from starting dose.
Lorazepam	Restlessness Anxiety Agitation Nausea/Vomiting	Oral IV SC	0.5 mg	Every 1 hour until calm. Increase to 1 mg if no relief from starting dose.
Metoclopramide	Nausea/Vomiting	Oral IV	5-10 mg	Every 6 hours
Ondansetron	Nausea/Vomiting	Oral IV	4 mg	Every 8 hours. Increase to 8 mg if no relief from starting dose. **If using for opioid-induced nausea, give 30 minutes before morphine to prevent nausea
Morphine Sulfate	Pain Dyspnea	Oral	5-10 mg	Every 3-4 hours. ****Increase dose by 50% for pain unrelieved by starting dose at 1 hour for oral and 15 minutes for IV dose.** ****Introduce laxative**
		IV	2-4 mg	