COVID-Ready Communication Skills
Adapted from
COVID-Ready Communication Skills, a playbook of VitalTalk Tips

Institute for Human Caring
Providence St. Joseph Health

Deciding — When things aren't going well, goals of care, code status

What they say	What you say
I want everything possible. I want to live.	I hear you clearly. We will continue to give you the best care we can. This is a tough situation. Could we step back for a moment so I can learn more about you? ***What do I need to know about you to do a better job taking care of you?***
I don't think my spouse would have wanted this.	Well, let's pause and talk about what s/he would have wanted. Can you tell me what has been most important in her/his life? ***What means the most to her/him and gives her/his life meaning?***
I don't want to end up being a vegetable or on a machine.	Thank you, it is very important for me to know that. ***Can you say more about what you mean?***
I am not sure what my spouse wanted—we never spoke about it.	Many people find themselves in the same boat. This is a hard situation. To be honest, your spouse is very sick. If we need to put her/him on a breathing machine or do CPR, I do not think s/he will survive. This is hard for me to say, but the odds are just against us. ***My recommendation is that we accept that s/he will not live much longer and allow her/him to die peacefully.*** I imagine that may be hard to hear. What do you think?

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Resourcing in a Crisis — When limitations force you to choose, and even ration

What they say	What you say, and why
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. **[C]***
Why can't my 90 year old grandmother go to the ICU?	This is a very difficult time and situation. **The truth is that whatever we do, it is very likely that your grandmother will die.** *I wish that wasn't the case, but it is.* ***There is a team of experienced doctors who are responsible for making very difficult decisions about using limited ICU beds during the pandemic. It is not up to me. They will be reviewing her case.*** It is possible that given your grandmother's condition, she may not be able to go to the ICU during this crisis situation. If that happens, I promise you that we will take good care of her for as long as she lives. **[C]***
Shouldn't I be in an intensive care unit?	The hospital is being forced to use special rules about treating patients in the ICU because we are trying to use our resources in a way that is fair for everyone. ***There is a team of experienced doctors who are responsible for making very difficult decisions about using limited ICU beds during the pandemic. It is not up to me.*** Unfortunately, your condition may not meet criteria for the ICU right now. ***If it were not for this public health crisis, we might be making a different decision. This is an extraordinary time.*** I wish I had more resources – we all do. **[C]***
Are you just discriminating against her because she is old?	I can see how it might seem like that. You really care about her. **No, we are not discriminating.** *We are trying to make the best decision for each individual patient, based solely on a person's medical condition and likelihood of benefiting from treatments.* *During this crisis, if there are not enough ICU beds or ventilators for every patient who needs them, we can rely on public health guidelines for how to give good and just care.* ***These guidelines were developed by people of multiple religions and ethnic backgrounds*** *and included* health care professionals, ethicists, spiritual leaders and lay people who considered all the pros and cons in *preparing for a public health crisis like this*. The guidelines we are using have been approved by the leadership of Providence and are consistent with state government guidelines. **[C]***

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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. But, honestly, this is not discrimination. We strongly believe that every person has dignity and worth. The situation today is that critical 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. **[C]***
It sounds like you are rationing.	We are trying to use limited resources fairly. ***I wish we had more for every single person in this hospital, but we don't.*** **This situation affects us all.** **Many of us have colleagues, friends and family members who are ill and need care.** **[C]***
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 limited 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. **[C]***
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. ***I realize that must be disappointing to hear.*** **[C]***
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 we can. The hard fact is that h/she is dying even with our best efforts. We are in an extraordinary time, and we are following special guidelines that apply to everyone. We cannot continue to provide critical care to patients who are not getting better. Sadly, this means that we need to accept that s/he will die, and that we need to take her/him off the ventilator. I wish things were different. **[C]***
Who made this decision?	I can't imagine how frustrating this decision is. It was made by team made up of experienced doctors who are trying to spread out resources in the best way possible. I wish we had more for every person here. As their doctor, I do not participate in that process. I do promise as their doctor I will continue to provide the best care possible for them and ensure that their death is as comfortable as possible. **[C]***

[C] = For Communicating only during a crisis.
* While all clinicians may need to know how to respond to these questions, best practice would be for a physician member of the team to be the first person to discuss this with a patient or family.

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Notifying — When you are telling someone over the phone

What they say	What you say
Yes I'm his daughter. I am 5 hours away.	I'm sorry to be having this conversation by phone. I am calling with serious news. Are you in a place where you can talk?
What is going on? Has something happened?	I am calling about your father. He died a short time ago. The cause was COVID19.
[Crying]	I am so sorry for your loss. [Silence][If you feel you must say something: Take your time. I am here.]
I knew this was coming, but I didn't realize it would happen this fast.	I can only imagine how shocking this must be. It is sad. [Silence] [Wait for them to restart]

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For more COVID-19 communication tips review the Center to Advance Palliative Care COVID Resources

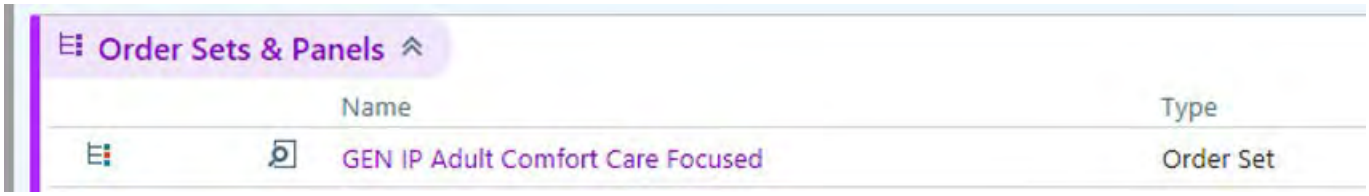
Download the VitalTalk Tips App (iOS or Android)

VITAL talk

Electronic Health Record Resources (EHR)

Comfort care order set exists in both the Epic and Meditech EHRs. These order sets contain commonly used medications and dosing for control of common symptoms. These can be accessed by:

1) **Epic** - From the orders navigator, search for the "GEN IP Adult Comfort Care Focused" order set



2) **Meditech** - From the order set menu, search for Comfort Care Adult SS (OC/HD), N Comfort Care End of Life (NorCal), or T Palliative Medicine (Texas).

Southern California example

Updated 3/19/20

Symptom Medications

COVID-19 Clinical Resource

Center to Advance Palliative Care℠ 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.

Prescribing Opioids: A Reference Guide

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Starting Doses in the Opioid-Naïve Patient
START LOW AND TITRATE BASED ON RESPONSE

Drug Name	Oral Dose	Intravenous Dose
Morphine	7.5 mg (15 mg pill cut in half)	2 mg
Hydromorphone	1 mg (2 mg pill cut in half)	0.2 mg
Oxycodone	2.5 mg (5 mg pill cut in half)	—
Hydrocodone	5 mg	—

CAUTION: Prescribers should always consult the individual drug monographs for comprehensive information. Transdermal fentanyl should not be used in the opioid-naïve patient.

Equianalgesic Conversion Table

Drug Name	Equianalgesic Dose		Oral to Parenteral Ratio
	Oral (mg)	Parenteral (mg)	
Morphine	25	10	5:2
Hydromorphone	5	2	5:2
Oxycodone	20	n/a	n/a
Hydrocodone	25	n/a	n/a
Oxymorphone	10	1	10:1

Potency ratios:
→ oral morphine: oral hydromorphone is 5:1
→ oral morphine: oral oxycodone is 1.25:1
→ oral morphine: IV hydromorphone is 12.5:1
→ transdermal fentanyl 25mcg/hr: oral morphine 50mg/24hr

Oral hydromorphone is 5 times as potent (mg per mg) **as oral morphine**

This conversion table is adapted from: McPherson ML. Demystifying Opioid Conversion Calculations: A Guide for Effective Dosing, 2nd ed. American Society of Health-System Pharmacists, Bethesda, Maryland, 2018.

Common Dosing Strengths and Availabilities

Formulation	Strength
Morphine Sulfate	IR 15 mg, 30 mg
Morphine Sulfate Oral Solutions	10 mg/5 ml, 20 mg/5 ml Also available in a highly concentrated 20mg/ml solution
Morphine Sulfate ER	15 mg, 30 mg, 60 mg, 100 mg, 200 mg
Oxycodone IR	5 mg, 10 mg, 15 mg, 20 mg, 30 mg
Oxycodone Oral Solutions	5 mg/5ml and 20 mg/ml
Oxycodone ER	10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 60 mg, 80 mg
Hydromorphone	2 mg, 4 mg, 8 mg
Hydromorphone ER	8 mg, 12 mg, 16 mg, 32 mg
Oxymorphone IR	5 mg, 10 mg
Oxymorphone ER	5 mg, 7.5 mg, 10 mg, 15 mg, 20 mg, 30 mg, 40 mg
Fentanyl Patch	12 mcg/hour, 25 mcg/hour, 50 mcg/hour, 75 mcg/hour, 100 mcg/hour
Methadone	5 mg, 10 mg
Methadone Oral Solutions	5 mg/5 ml, 10 mg/5 ml, 10 mg/ml
Buprenorphine Transdermal System	5 mcg/hour, 10 mcg/hour, 15 mcg/hour, 20 mcg/hour