Management of symptoms for all COVID-19 patients

COMMUNICATE with sensitivity and compassion with the patient and those closest to them. INVOLVE patient (where possible) and those closest to them in decisions as much as they want. SUPPORT & explore holistic needs of patient and those closest to them. Be mindful family may not be able to visit, is there an alternative way for them to talk?

Write, Phone, Text, Face-time

Patients dying acutely from COVID related acute respiratory distress syndrome

The bottom line is that, if a patient is going to die, we need to ensure they die without distress

- Morphine 5-10mg SC prn hourly (oxycodone 2.5 – 5mg prn hourly if eGFR < 30) – for breathlessness
- Midazolam 5-10mg SC prn hourly for anxiety/distress
- Glycopyrronium 400 micrograms SC prn hourly for any respiratory secretions
- Consider levomepromazine 5 – 12.5mg SC prn 4 hourly if nauseated

Once no longer distressed and if not dying within short number of hours then start syringe driver morphine 20mg and midazolam 20-30mg CSCI though this dose will need to be adjusted according the response to the prn medication

Doses may not fit with established practice and may need to be determined on a case by case basis. Do use advice from the palliative care team or Pilgrims Hospice out of hours 01233 504133

Patients where non-invasive ventilation(CPAP/BiPAP) is being discontinued as the patient is dying

This requires the right medication to be put in place and careful management Whilst the following guide is a suggestion, discussion with the palliative care team is strongly recommended

- Start syringe driver (CSCI) morphine 20mg and midazolam 30mg over 24 hours at least 3 hours prior to stopping ventilation AND ensure patient is not responsive to voice or physical stimuli before ventilation removal
- Have morphine 10mg and midazolam 10mg drawn up ready to give the patient subcut if distressed when mask is removed and consider whether to abort ventilation removal until patient an adequate level of sedation is achieved – seek palliative care advice in this situation.

Patients dying from other conditions but happen to be COVID positive

See guidance on next page

All patients require effective symptom control even if they may survive from their COVID illness

There is no convincing evidence that the agreed symptom control guidance causes significant respiratory depression or leads to worse outcomes in this group. It may be that outcomes are better with improved compliance and reduced anxiety and discomfort

See guidance on next page

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For all COVID-19 patients, please ensure the following symptoms are considered and PRN/regular medication prescribed:

Symptom	Recommendation	If injectable route not available (community or care home setting), consider
Breathlessness AND/OR Pain	Morphine 2.5mg – 5mg subcut. 2 hourly prn **OR** Oxycodone 1 – 3mg subcut. if eGFR <30 and then commence subcut. syringe driver as above **If patient still able to swallow:** Morphine Sulphate liquid 5mg 2 hourly PRN **OR** Oxynorm 2.5mg if eGFR<30 Paracetamol PO for pain ***Avoid fans if risk of spreading infection****	Paracetamol 500mg-1g *supps* PR for pain Zomorph *capsules* can be opened and sprinkled onto food Buprenorphine patch: Starting dose depending upon conversion from oral opioid Fentanyl patch: High potency – use only if converting from higher oral doses *Note patches will take 24 hours to have significant effect and risk of increased absorption with fever - use last resort* Abstral (sublingual Fentanyl) could be an alternative - starting dose 100 micrograms which may be repeated after 15-30 minutes. Seek advice if further titration required.
Respiratory secretions	Glycopyrronium 200 – 400 micrograms 1 hourly subcut. PRN. Max 2.4mg/24hours (Subcut syringe driver 1.2-2.4mg/24Hrs) **OR** Buscopan (Hyoscine Butylbromide) 10mg-20mg 1 hourly subcut. PRN up to 120mg/24 hrs initially. (Subcut. syringe driver 120mg/24hrs) ***Avoid suction****	Hyoscine Hydrobromide *(Kwells)* 300micrograms SL tablets 6 hourly Hyoscine Hydrobromide (*Scopaderm)*1mg/72hrs patch may need up to 4 patches Atropine 1% drops (Ophthalmic drops) 2 drops sublingually every 2-4hrs
Anxiety	Midazolam 2.5 – 5mg mg subcut 2 hourly prn If persistent anxiety, consider a subcut infusion via a syringe pump (starting dose Midazolam 10mg/24hrs) If oxygen only needs to be continued for anxiety reasons minimise flow rate	Lorazepam *tablet* 0.5mg sublingually up to hourly PRN if patient still able to swallow. Usual maximum 4mg/24hrs Oxazepam *tablet* 5mg-10mg sublingually up to hourly PRN. Usual maximum 40mg/24hrs Buccal midazolam 5- 10mg can be used at home or in care home
Cough	Simple linctus-5mls QDS PO **OR if ineffective:** Codeine phosphate linctus-15mg QDS PO **OR** Morphine Sulphate liquid 2.5mg 4 hourly PO **OR** Morphine sulphate inj. 2.5mg subcut. 2 hourly PRN	
Delirium	Haloperidol tablets/oral solution or subcut 0.5mg-1mg every 2-4hrs (Subcut. syringe driver 2.5-5mg/24hrs if persistent symptoms) **If distressing agitation unresponsive to usual measures consider:** Midazolam 5mg subcut 2 hourly (Subcut. syringe driver 10-20mg/24hrs) Levomepromazine 12.5mg subcut 4 hourly (Subcut. syringe driver 50mg/24hrs)	Risperidone *orodispersible tablet* 0.5-1mg OD/PRN Olanzapine *velotabs tablet* 5-10mg OD/PRN Buccal midazolam (5mg/ml) pre-filled syringes 5mg-10mg Can be repeated after 10 minutes if rapid sedation needed. 5mg if weight <50kg or elderly Midazolam ampoules can also be used via buccal route Consider Diazepam PO 2.5mg to 10mg 2-4 times a day but may worsen symptoms. Rectal Diazepam pre-filled syringes may also be considered.
Nausea or vomiting	Cyclizine 50mg PO/subcut. 8hourly (Subcut. syringe driver 150mg/24hrs) Levomepromazine 5 – 12.5mg PO/subcut. 4hourly (Subcut. syringe driver 5-25mg/24hrs) Haloperidol 0.5-1mg PO/subcut. 4hourly (Subcut. syringe driver 2.5-5mg/24hrs)	Hyoscine Hydrobromide *(Kwells)* 300micrograms sublingual tablets 6 hourly Ondansetron *orodispersible tablets* 4-8mg 8-12 hourly Prochlorperazine *buccal tablets* 3mg-6mg 12 hourly Domperidone *suppositories* 30mg PR 12 hourly Olanzapine *velotabs tablet* 5-10mg OD/PRN
Fever	Regular antipyretics such as paracetamol PO 1g QDS. Max 4g/24 hours Use of NSAIDs not recommended in COVID-19. However, if a patient is close to the end of life, it may be appropriate to consider use of NSAIDs e.g. Oral Ibuprofen 400mg TDS if able to swallow **Or** Diclofenac 75mg SC/IM 12 hourly **Or** Parecoxib 10-20mg subcut. 4-6 hourly ***Avoid fans if risk of spreading infection****	

****Sedation and opioid use should not be withheld because of an inappropriate fear of causing respiratory depression****

References:
Association for Palliative Medicine COVID-19 and Palliative, End of Life and Bereavement Care in Secondary Carewww.apmonline
Scottish Palliative Guidance https://www.palliativecareguidelines.scot.nhs.uk/