

Clinical guidelines for symptom control in patients with Covid-19 (2 pages)

In **acute phase of Covid-19** it is important patients have their symptoms controlled **alongside** active medical treatment.

Most common symptoms in last days of life are pyrexia, rigors, severe breathlessness, cough, delirium and agitation.

NB Opioid and benzodiazepine use in palliation should not be withheld because of fear of causing respiratory depression.

For all Covid-19 patients, please ensure the following symptoms are considered and **prn/regular** medication prescribed:

SD =syringe driver **sc** =subcutaneous **MR** =modified release **IR** =immediate release **SL**=Sublingual **TDD**= total daily dose

Symptom	Clinical indication	Recommendation
Breathlessness (at rest or minimal exertion)	Opioid naïve (no previous opioids) and able to swallow	1st line Morphine sulphate MR (modified release) oral 5 mg (MST)12 hourly and increase as necessary to 15mg 12 hourly (Max 30mg/24 hours) NB If eGFR <30 mL/min oral oxycodone MR 5mg 12 hourly
		Alternative Morphine sulphate IR (immediate release) oral 2 to 5mg 2 to 4 hourly prn NB If eGFR <30 mL/min Oxycodone IR oral 1 to 2 mg 2 to 4 hourly prn
	Patients on regular opioids for pain relief	Morphine sulphate IR oral 2 to 5mg 2 to 4 hourly prn or one twelfth of the 24 hour dose for pain, whichever is greater. NB If eGFR <30 mL/min Oxycodone IR oral 1 to 2 mg 2 to 4 hourly prn
	Patients who are unable to swallow use subcutaneous(sc) medications	a) opioid naïve Morphine sulphate 2mg sc 2 to 4 hourly prn If > 2 doses required per day, consider a syringe driver (SD) Starting dose SD morphine sulphate 10mg/24hour NB If eGFR <30 mL/min Oxycodone 1 to 2 mg sc 2 to 4 hourly prn If > 2 doses use a SD Oxycodone 5mg/24 hour b) already on regular opioids (oral or transdermal) refer to conversion charts on 'Anticipatory Drugs and Syringe Driver Chart' and note the advice above: 'Patients who are on regular opioids for pain relief'
Anxiety	Patients who can swallow	Lorazepam 500micrograms to 1mg SL 2 to 4 hourly prn Max 4mg/24 hours (2mg in elderly patients)
	Patients unable to swallow	Midazolam 2 to 5mg sc 2 to 4 hourly prn If > 2 doses required daily, consider a syringe driver Starting dose SD Midazolam 10mg/24hour Max 30mg/24hours NB If eGFR <30mL/min reduce starting dose SD Midazolam 5mg/24hr
Cough	Opioid naïve	1st line Simple linctus 5mL qds 2nd line Opioids dosing as for breathlessness see above
Fever		Regular Paracetamol (Fan use & PR route may spread the virus) In the last days of life consider an NSAID e.g. Parecoxib 40mg sc daily
Delirium	Potentially reversible	<i>Pharmacological measures only indicated in severe delirium with distressing hallucinations or severe agitation.</i>
	NB In Parkinson's patient use Lorazepam as 1 st line	1st line Haloperidol 500micrograms to 1mg oral /sc stat . Observe for 30 to 60 minutes. Repeat if necessary and thereafter 8 hourly prn . Max 5mg/24 hours 2nd Line (1st line in Parkinson's Disease) Lorazepam 500microgram to 1mg SL 2 to 4 hourly Max 4mg/24 hour (2mg in elderly patients) Be aware that benzodiazepines may increase levels of confusion
	Irreversible terminal delirium/agitation not expected to recover. Patient is dying	1st line Midazolam 2 to 5 mg sc 1 to 4 hourly prn If > 2 doses required daily, consider a SD Starting dose SD Midazolam 10mg/24hour Max 60mg/24hours NB If eGFR <30 mL/min SD Midazolam to 5mg/24 hour Max 30mg/24hours
	Seek advice from palliative care if 1 st line midazolam not helping as 2 nd line drug doses may need to be escalated rapidly	2nd line Levomepromazine or Haloperidol and continue midazolam in SD Levomepromazine 12.5mg to 25mg sc 1 to 4 hourly prn SD 25mg/24hour Max 100mg/24hr NB If eGFR <30 mL/min or elderly use lower starting doses Levomepromazine 6.25mg to 12.5mg sc 1 to 4 hourly prn SD 12.5mg/24hour OR Haloperidol 500micrograms to 1mg sc 1 to 4 hourly prn SD 3 mg over 24 hour Max 5mg/24 hour
Pain	Use WHO analgesic ladder	Step 1 Paracetamol, Step 2 weak opioids Step 3 morphine IR 2 to 5mg 2 to 4 hourly and titrate Convert to morphine MR. prn dose is total daily dose(TDD)divided by 6 If eGFR <30 mL/min use oxycodone IR 1 to 2mg 2 to 4 hourly and titrate
	Conversions for a SD sc prn dose =TDD/6	Oral morphine to sc morphine divide by 2 Oral oxycodone to sc oxycodone divide by 2 If on a transdermal patch keep in situ and top up with sc opioid prn and/or SD

NB If starting a regular opioid, then consider starting a prn laxative (e.g. Laxido 1 to 2 sachets bd **prn** or picosulphate 5 to 10mL od **prn**) and antiemetic (e.g. haloperidol 500micrograms to 1mg oral/sc 8 hourly **prn**) If a patient **rapidly deteriorates despite active management** then please follow the **last days of life documentation**.

Non-pharmacological symptom control in patients with Covid-19

Use of non-drug symptom management strategies can help relieve symptoms and reduce reliance on medications
Generally non-drug approaches to symptom management are preferred, particularly for mild to moderate symptoms

Symptom	Non-pharmacological measures
Breathlessness (at rest or minimal exertion)	- Positioning (Sit upright, legs uncrossed, let shoulders droop, keep head up; lean forward) - Relaxation techniques - Reduce room temperature - Cooling the face by using a cool flannel or cloth - Reassurance Avoid portable fans due to infection control risk in COVID-19
Anxiety	- Facilitate expression of emotions - Explore fears and concerns - Address spiritual or religious needs - Distraction – e.g. playing music or radio - Offer reassurance
Cough	- Suck on menthol sweets (e.g. Fisherman's friend) - Humidify room air - Oral fluids - Elevate the head when sleeping
Fever	- Reduce room temperature - Wear loose clothing - Cooling the face by using a cool flannel or cloth - Oral fluids Avoid portable fans as infection control risk
Delirium	Check for reversible causes - Infection - Electrolyte disturbance - Dehydration - Hypoxia - Hyper/hypoglycaemia - Urinary retention - Constipation - Pain - Medication related - Medication or alcohol withdrawal - Reorient (explain where they are, who you are etc) and reassure - Ensure lighting levels mimic the time of day - Ensure the patient has access to glasses and hearing aid if applicable - If family members can be present involve them in reassuring patient - Ensure continuity of care by staff known to patient where possible - Avoid moving people within and between wards or rooms unless absolutely necessary
Agitation/ Terminal restlessness	Check for reversible causes: - Urinary retention - Constipation - Pain – remember to check both syringe driver functioning correctly and skin site - Repositioning - Reassurance - Calm surrounding environment

If you require advice , please contact the Specialist Palliative Care Team directly on the numbers below			
York Specialist Palliative Care team (SPCT)		Scarborough Specialist Palliative Care team (SPCT)	
In hours	- Community SPCT 01904 777770 - Hospital SPCT 01904 725835 - St Leonard's Hospice 01904 708553	In hours	- Community SPCT 01723 356043 - Hospital SPCT 01723 342446 - St Catherine's Hospice 01723 351421
Out of hours	- GP OOH 0300 1231 183 - St Leonard's Hospice 01904 708553	Out of hours	- GP OOH NHS 111 - Palcall 01723 354506
Community nursing	Single point of access (SPA) 01904 721200	Community nursing	S&R Community Services (CAS) 01653 609609
There is always access to a consultant on call via your local hospice			

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