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 NB In Parkinson's patient use Lorazepam as 1st line	*Pharmacological measures only indicated in severe delirium with distressing hallucinations or severe agitation.* **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 Seek advice from palliative care if 1st line midazolam not helping as 2nd line drug doses may need to be escalated rapidly	**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
		2nd line Levomepromazine or Haloperidol and continue midazolam in **SD** Levomepromazine12.5mg 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

Author York Teaching Hospitals Palliative Care team in collaboration with St Leonard's Hospice ,St Catherine's Hospice
Adapted from Hull University Teaching Hospitals NHS Trust guidance
Owner Dr Anne Garry Issue date 31st March 2020 Review date 31st March 2022 Version 2

Saint Catherine's
Caring for you at Hospice and Home

St Leonard's Hospice
Caring for Local People

NHS
York Teaching Hospital
NHS Foundation Trust