Seek advice and support from your local Specialist Palliative Care Team.
Summary based on NICE guidance NG163 https://www.nice.org.uk/guidance/ng163/resources/covid19-rapid-guideline-managing-symptoms-including-at-the-end-of-life-in-the-community-pdf-66141899069893 and https://elearning.rcgp.org.uk/mod/page/view.php?id=10389

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Community Symptom control and patient support including for the last days of life during the COVID-19 pandemic (Adults only)

(V4 dated 16 Apr 2020. Adapted from Surrey Heartlands Health and Care Partnership guidance April 2020.)

- **For children and young adults under 18 years seek advice and guidance.**
- **Consider accessing local specialist palliative care teams for advice and guidance if required**

This is a short clinical summary agreed by local specialist palliative care teams. Clinicians should also refer to the latest Palliative Care in Covid-19 information, which provides detailed advice on all aspects of patient care when symptom and Palliative Care is considered. NICE NG163 Covid19-managing symptoms including at the end of life care in the community https://www.nice.org.uk/guidance/ng163/resources/covid19-rapid-guideline-managing-symptoms-including-at-the-end-of-life-in-the-community-pdf-66141899069893 and Royal College of General Practice https://elearning.rcgp.org.uk/mod/page/view.php?id=10389 .

As deterioration can sometimes be very rapid, prepare and discuss any escalation plans with patient and family as for critical care they may need rapid transfer to hospital.
ONLY PRESCRIBE WHAT IS IMEDIATELY REQUIRED IN ORDER TO ENSURE ALL PATIENTS GET ACCESS TO THE MEDICATION THEY NEED FOR SYMPTOM CONTROL.
Correct the correctable – give antibiotics for a bacterial infection Check for latest guidance https://www.nice.org.uk/
Consider maintenance of adequate hydration *(little and often, maximum 2 litres per day)*
Consider syringe pump only if oral route is unavailable
Route of Administration: PO=Oral **IR** =immediate release **SL**=Sublingual **SD** =syringe driver **SC** =subcutaneous **MR** =modified release **TDD**= total daily dose **PR**=Rectal
Directions: OD = once daily **BD**= twice daily **TDS**= three times daily **QDS**= four times daily **ON**= at night **PRN**= as required/needed

Hospice Contact Details: East Berkshire - Thames Hospice 01753 848925 **Surrey Heath and North East Hants or Farnham - Phyllis Tuckwell Hospice on 01252 79-29440**

Starting doses in opioid naïve patients:

- Consider anti-emetic + laxative for morphine/opiate side-effects
- If patients are not responding to initial dose, consider titrating within dose range and seek advice
- If patients are already on an opioid, consider an appropriate starting dose (if already on morphine increase dose by a third)

Symptom	Non-pharmacological approaches	Oral route	Subcutaneous route	Syringe pump doses	Comments
Cough *Ensure the patient is not going to choke.*	Humidify room air Oral fluids *(little & often)* Teaspoon of honey Honey and lemon in warm water Suck cough drops/boiled sweets Elevate head when sleeping Avoid lying on back as it reduces the ability to cough Avoid smoking	Simple linctus-5mls QDS PO **OR** *Glycerin and honey (available to purchase)* **OR If ineffective:** Codeine phosphate linctus-15mg/5ml 30-60mg QDS PO 200ml *(also available sugar free)* OR use Codeine tablets (15mg or 30mg) **OR Morphine Sulphate (10mg/5ml) oral solution.** 2.5mg 4 hourly PO *(and titrate up according to response.* Renal failure, (EGFR<30) consider Oxycodone.	Morphine sulphate inj. 2.5mg SC two hourly PRN Renal failure, (EGFR<30) consider Oxycodone	If unable to take oral medication: morphine sulphate 10mg/ 24hrs starting dose. Renal failure, (EGFR<30) consider Oxycodone	Seek advice from local palliative care team *Only prescribe morphine/codeine as an acute medication and discuss side effects, also be aware of the potential for dependency.* *Avoid in patients with chronic bronchitis or bronchiectasis and seek advice- if not end of life.*

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Symptom	Non-pharmacological approaches	Oral route	Subcutaneous route	Syringe pump doses	Medications via alternative routes
Breathlessness *Opioids may reduce perception of breathlessness. Identify any reversible causes* *If oxygen is available, consider a trial*	Cool flannel around the face and nose. *Change and wash frequently.* Positioning of patient *(NICE NG163 table 3)* Improve air circulation in the room e.g. Open window Portable fans are NOT recommended due to infection risk for others	**Morphine sulphate (10mg/5ml) oral solution** 2.5-5 mg PO PRN 2 hourly and titrate up according to response **OR** Morphine sulphate modified release 5mg PO BD and titrate to response Renal failure, (EGFR<30) consider Oxycodone 1mg-2mg PO 2hourly Consider addition of a benzodiazepine such as Lorazepam (0.5mg - 1mg up to 4 hourly sublingually)	Morphine sulphate 2.5-5mg SC PRN 2 hourly and titrate to response **AND/OR** Midazolam 2.5-5mg SC for associated agitation or distress due to breathlessness In renal failure, (EGFR<30) consider Oxycodone 1-2mg SC 2 hourly	Morphine sulphate 10mg/24 hours and titrate according to response In renal failure (EGFR <30), consider halving dose or oxycodone 5mg/24hours and titrate according to response Consider midazolam 5 – 10mg/24 hours	**Seek advice from palliative care team** Morphine sulphate (10mg/5ml) oral solution by the buccal route *(draw up in oral syringe then put into side of mouth and rub cheek to enable absorption). Unlicensed route.* Buprenorphine transdermal patches starting at 5-10mcg/hr every 7 days *(patches take additional time to provide adequate symptom relief)*
Anxiety/Delirium /Agitation *Ensure effective communication and reorientation.* *Provide reassurance*	Consider and treat underlying causes - blocked catheter, constipation, hypercalcaemia, hypoxia etc. Reduce stimuli: -Avoid loud noises -Avoid bright light -Reduce number of people in room Consider relaxation CDs, breathing exercises (extend 'out' breath) etc.	**Anxiety:** Lorazepam 0.5mg-1mg SL QDS Max 4mg in 24 hours **Delirium:** Haloperidol 500 micrograms-1mg PO at night and every 2-4 hr PRN (*tablets or oral solution*) Max 5mg in 24 hours	**Delirium**: Haloperidol 500micrograms -1mg SC every 2 hours Max 5mg in 24 hours Or Levomepromazine 6.25mg SC 4 hourly. **Agitation:** Midazolam 2.5mg-5mg PRN hourly **AND/OR** Levomepromazine 12.5mg -25mg SC titrate dose according to response	Haloperidol syringe pump 1.5mg -5mg can be increased to 10mg/24hrs Or Levomepromazine 6.25 - 12.5mg / 24 hours titrated in increments of 6.25 – 12.5mg **Seek advice from palliative care team** **Anxiety / agitation,** Midazolam 10mg -20mg/24 hrs titrate to response In renal failure, (EGFR<30) reduce to 5mg/24hours **AND/OR** Levomepromazine 50mg-150mg SC /24hrs	**Discuss with local specialist palliative care team, before considering prescribing** Midazolam oromucosal (buccal) solution - administer 0.5-1ml PRN hourly (Buccolam 10mg/2ml prefilled oral syringe) (Epistatus 10mg/ml prefilled oral syringe) *(Normally only used as part of shared care plan in epilepsy)* Olanzapine orodispersible5mg tabs 2.5mg (5mg tabs can be halved) 4hourly to max 10mg/day
Pain	Heat pads over affected areas Massage	Paracetamol 1g PO QDS If patient under 50kg consider 500mg QDS *(tablet or liquid, soluble contains high level of sodium)* **Morphine sulphate (10mg/5ml) oral solution** 2.5-5mg PO PRN 2 hourly and titrate to response **OR** Morphine sulphate modified release 5mg PO BD (MST tablets) and titrate to response (Zormorph Capsules 10mg, 30mg, 60mg can be opened). In renal failure (EGFR<30), consider Oxycodone 1mg -2mg PO 2 hourly.	Morphine sulphate 2.5-5mg (1.25mg if elderly, frail, low weight) SC PRN 2 hourly and titrate to response In renal failure, (EGFR<30) consider Oxycodone 1-2mg SC 2 hourly. **Seek advice from local palliative care team**	Morphine Sulphate 10mg/24 hours and titrate according to response In renal failure (EGFR<30), consider halving dose or oxycodone 5mg/24hours and titrate according to response **Seek advice from local palliative care team**	**Seek advice from palliative care team** Buprenorphine transdermal patches starting at 5-10mcg/hr every 7 days *(patches take additional time to provide adequate pain relief)* Morphine sulphate (10mg/5ml) oral solution by the buccal route *(draw up in oral syringe then put into side of mouth and rub cheek to enable absorption). Unlicensed route*

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Other Symptoms – see local End of Life guidance or seek support from your local specialist palliative care team

Patients may also have fatigue, muscle aches and headache NICE NG163
The table below includes symptoms that patients experience due to co-morbidities but may not be seen in Covid-19 patients

Symptom	Non-pharmacological approaches	Oral route	Subcutaneous route	Syringe driver doses	Medications via alternative routes
Respiratory secretions	Positioning Reassurance for carers		Hyoscine Butylbromide 10mg-20mg SC 2-4hourly Max 240mg/24hr Glycopyrronium 200-400micrograms SC hourly (max 1.2mg/24 hrs)	Hyoscine Butylbromide 60mg -120mg/24hours Glycopyrronium 600micrograms -1.2mg /24 hours	Hyoscine hydrobromide patches (Scopoderm) 1mg/ 72 hourly – caution may worsen delirium Glycopyrronium injection applied buccally 200-400mcg SC hourly (max 1.2mg/24 hrs) Atropine SL 1% Minims (ophthalmic drops) 2 drops SL every 2-4 hours (*avoid In patients with delirium or dementia as can increase confusion). Unlicensed route.*
Nausea & Vomiting	Consider and treat underlying cause	Varies by cause: **Delayed gastric emptying**: Metoclopramide 10mg PO TDS **OR** Domperidone 10mg PO QDS **Raised intracranial pressure**: Cyclizine 50mg PO TDS **Biochemical disturbance:** Haloperidol 0.5-1mg PO BD **OR** Levomepromazine 6.25mg PO (*Discuss with local palliative team 25mg tablets)*	Haloperidol 0.5-1.5mg SC PRN hourly Levomepromazine 6.25mg SC PRN 4 hourly Cyclizine 25mg SC PRN/TDS	Haloperidol 1.5-5mg/24 hours Levomepromazine 6.25 - 25mg SC /24 hours Cyclizine 75mg SC /24hrs	Olanzapine 5-10mg tablets orodispersible PRN Max 10mg in 24hours Or Hyoscine hydrobromide patches (Scopoderm) 1mg/ 72 hours *(patches can take additional time to provide relief)*
Seizures		As per individual normal prescribed medication	Midazolam 5-10mg SC stat	Midazolam 20-30mg/24 hours if unable to take oral anti epilepsy medication	*Prefilled midazolam buccal solution Buccolam 10mg/2ml administer 1-2mls immediately OR as per care plan* *Epistatus 10mg/ml administer as per care plan* **Discuss with local palliative care team**

- Continue to use your Local Medication and Administration Records (MAR) charts to record and administer any medication, a prescriber does NOT need to sign before giving to the patient.
- Palliative Care Drugs - access through Community Pharmacy
- Respiratory information in Covid-19 https://www.pcrs-uk.org/sites/pcrs-uk.org/files/resources/COVID19/Primary-Care-and-Community-Respiratory-Resource-Pack-during-COVID-19-final-28.3.20.pdf
- Hyper-salivation in adults https://surreyccg.res-systems.net/PAD/Content/Documents/2/Hypersalivation%20Pathway%20Adults-%20Final%20Jan%2020.pdf
- NICE NG165 Managing suspected or confirmed pneumonia in Adults in the Community https://www.nice.org.uk/guidance/ng165
- NICE Covid-19 managing symptoms https://www.nice.org.uk/guidance/ng163/resources/covid19-rapid-guideline-managing-symptoms-including-at-the-end-of-life-in-the-community-pdf-66141899069893
- When prescribing consider the route of administration, potential waste, medicines shortages, lack of staff and equipment and the availability of friends or family to support the patient.