The Mid Yorkshire Hospitals NHS Trust

Managing common end of life symptoms in patients with COVID-19 WHEN A SYRINGE DRIVER IS NOT AVAILABLE

This guidance is intended for situations where a syringe driver is not available for those patients who have distressing symptoms and are **dying**. The guidance is not aimed at those who are being actively managed with the expectation of recovery. **These guidelines are for use in community.**

It is recognised that symptoms can develop very quickly and that drugs may need to be titrated rapidly. Therefore in the event that syringe drivers are not available PRN drugs may need to be given frequently. **Where possible consider training carers to administer SC medication (protocol available)**

The specialist palliative care team will be able to provide additional advice and guidance but it will not be possible for them to provide direct care to everybody, especially as the pandemic progresses.

For management of other symptoms please refer to usual Symptom management guidelines which is available on EPaCCs.

Breathlessness

Non-pharmacological management

- Positioning* (various advice depending on position: sit upright, legs uncrossed, let shoulders droop, keep head up; lean forward). *where possible
- Relaxation techniques.
- Reduce room temperature.
- Cooling the face by using a cool flannel or cloth.
- Oxygen for symptomatic relief of hypoxia **(avoid 02 humidification and high flow)**

Portable fans are not recommended for use during outbreaks of infection or when a patient is known or suspected to have COVID-19

If a patient can swallow:	If a patient cannot swallow:
Morphine IR (oramorph or sevredol tablets) PO 2.5-5mg (PRN 1-2 hourly) **THEN ADD** Lorazepam 0.5-1mg SL (PRN 4 hourly) Max 4mg /24hours **IF NEEDING REGULARLY** Regular 4 hourly administration with PRN doses in between as needed (or escalate to SC medication) Consider Fentanyl patch 12-25mcg/hr ONLY IF PROGNOSIS FELT TO BE DAYS RATHER THAN HOURS	Morphine SC 2.5-5mg (PRN 1-2 hourly) Consider increasing dose of Morphine if not effective. **THEN ADD** Midazolam SC 2.5-5mg (PRN 1-2 hourly) OR Buccal Midazolam 10mg/ml prefilled syringe (PRN 1-2 hourly) **IF NEEDING REGULARLY** Consider Fentanyl patch 12-25mcg/hr **OR** Morphine MR **PR (off licence)** 10-30mg BD

Fever

- Reduce room temperature, loose clothing
- Cooling the face by using a cool flannel or cloth
- **Paracetamol 1g QDS PO/PR**
- NSAIDS may be considered in patients in the last days of life

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Agitation / Delirium

Identify and manage reversible causes where possible (SOB, pain, constipation, urinary retention, medication, psychological distress)

If a patient can swallow:	If a patient cannot swallow:
Lorazepam 0.5-1mg SL (PRN 4 hourly) Max 4mg /24hours **THEN ADD** Levomepromazine PO 6.25-25mg (PRN 4 hourly) Can be crushed **IF NEEDING REGULARLY** Regular 4 hourly administration Lorazepam with PRN doses in between as needed. **PLUS** Levomepromazine PO 25mg ON	Midazolam SC 2.5-5mg (PRN 1-2 hourly) OR Buccal Midazolam 10mg/ml prefilled syringe (PRN 1-2 hourly) **THEN ADD** Levomepromazine SC 12.5-25mg (PRN 4 hourly) **IF NEEDING REGULARLY** Levomepromazine SC 12.5-25mg OD/BD

Pain

If the patient can swallow:	If the patient cannot swallow:
Morphine IR (oramorph or sevredol tablets) PO 2.5-5mg (PRN 1-2 hourly) **May need larger dose if on regular background opioids** (continue while able) **IF NEEDING REGULARLY** Regular 4 hourly administration with PRN doses in between as needed. Consider Fentanyl patch based on opioid usage (12-25mcg/hour may be a starting dose)	Morphine SC 2.5-5mg (PRN 1-2 hourly) **May need larger dose if on regular background opioids** (see opioid conversion chart) Consider increasing dose of Morphine if not effective. **IF NEEDING REGULARLY** Consider Fentanyl patch based on opioid usage (12-25mcg/hour may be a starting dose)

Respiratory secretions

Hyoscine hydrobromide (scopaderm) patch 1mg/72 hours, max 2mg (can worsen delirium)
THEN ADD
Atropine 1% ophthalmic solution used ORALLY, up to 4 drops QDS. Likely only to be effective if thin watery solutions.
THEN ADD
Hyoscine butylbromide 20mg SC (PRN or regularly 4 hourly) max 120mg/ 24hrs

Prescribing considerations

As in all patients, consider renal function (eGFR <40), liver function and frailty when prescribing the above medication.

Alternative opioid in renal failure (eGFR <40) would be Oxycodone – see opioid conversion chart for doses)

If symptoms are not responding, or if you are not sure what to do please seek advice from the Palliative Care team.

If advice is needed please contact:

Specialist palliative care team: Monday to Sunday 9am – 5pm 01924 543 801 (Bleep 249)
Out of hours please contact: On-call palliative care consultant via MYHT switchboard
Wakefield Hospice: 01924 331 400 Prince of Wales Hospice: 01977 708 868
Standard guidance for managing other patients at the end of life can also be applied to patients with COVID19.