The Mid Yorkshire Hospitals NHS Trust

Managing common end of life symptoms in patients with COVID-19

This guidance is intended for those patients who have distressing symptoms due to COVID-19 infection and are not expected to survive. The guidance is not aimed at those who are being actively managed with the expectation of recovery. **These guidelines are for use both in hospital and community.**

This is adapted from Association of Palliative Medicine and NHS England guidance, and will be a 'live' document that will be updated, expanded and adapted as further contributions are received and in line with changing national guidance. (With thanks to the LTHT SPCT for adapting these for use).

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 MYHT Symptom management guidelines. There is specific guidance for symptom management when withdrawing ventilation and for syringe driver shortage. **In Hospital please consider consulting the eMeds protocol.**

Common symptoms are:

1. Breathlessness
2. Agitation/Delirium
3. Cough
4. Fever

Breathlessness

These guidelines assume that the patient is receiving all appropriate supportive treatments and that correctable causes of the symptoms have been considered and managed appropriately.
Examples include:
• Antibiotic treatment for a superadded bacterial infection may improve fever, cough, breathlessness and delirium.
• Optimising treatment of comorbidities (e.g. chronic obstructive airways disease, heart failure) may improve cough and 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.

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

Pharmacological management

- Oxygen for symptomatic relief of hypoxia **(avoid 02 humidification and high flow)**
- Opioids and benzodiazepines may reduce the perception of breathlessness. Measures are likely to be different to those usually taken for chronic breathlessness, and doses may need titrating to effect. Patients with extreme breathlessness are likely to need drugs via syringe driver or infusion pump. **Starting doses would typically be morphine 10mg and / or midazolam 10mg over 24 hours via syringe driver** but this may be altered in extremis, and approach similar to managing agitation at the end of life may be needed.
- **For prn doses standard guidance applies: Morphine 2.5-5mg sc and / or Midazolam 2.5-5mg sc,** but doses may need to be escalated, and consideration given to minimising unnecessary prn medication by using syringe drivers

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Delirium / Agitation

Standard non-pharmacological measures (reassurance from family members etc.) will be challenging in a COVID +ve patient but should be employed where possible. Identify and manage reversible causes where possible (SOB, pain, constipation, urinary retention, medication, psychological distress)

Standard guidance around **Midazolam applies with an initial dose 2.5-5mg sc prn**. If ineffective then titrate dose up to 10mg sc if needed. If patient remains agitated consider stat dose of Levomepromazine (12.5 - 25mg sc). At this point seek advice from Specialist Palliative Care team.

If 2 or more prn doses required, the patient is likely to need a continuous infusion. Starting doses should reflect medication that has been used and found to be effective, and would typically be midazolam 10mg-20mg/24hr. If midazolam has been ineffective, contact the palliative care team for advice.

Cough

Non-pharmacological measures may include: humidification of room air (bowl of hot water), oral fluids, honey and lemon in warm water, cough drops, elevation of head when sleeping

Opioids can be effective (**Codeine 30-60mg or Oramorph 2.5-5 mg PO 4 hourly, or Morphine 2.5mg subcutaneously**). If severe may need to consider Morphine via a syringe driver. A starting dose may be 10mg over 24 hours.

Fever

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

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Essential Mouth-care management (follow current recommended PPE guidance)

- Gently brush teeth twice a day with fluoride containing toothpaste if tolerated and acceptable to the patient
- Support patient to maintain adequate hydration and review medications which might cause dry mouth
- Use of pink foam mouth swabs / MC3 (moutheze) to gently cleanse the oral cavity 1-2 hourly as the patient tolerates if unconscious
- Apply dry mouth gel (e.g. BioXtra / Oralieve / Biotene oral balance gel) to lips, tongue and oral cavity 2-4 hourly

Prescribing considerations

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

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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.