COVID 19: Symptom Management in Last Days of Life Version 2 (October 2021)

This guidance is a supplement to the RPMG "Guidance for the Management of Symptoms in Adults in the Last Days of life" which should still be used as a reference.
http://www.professionalpalliativehub.com/sites/default/files/RPMG%20End%20of%20Life%20Guidance%202018.pdf

This guidance has been developed given the extreme challenges that may arise because of COVID-19 pandemic.
It is specifically for use in patients in the last days of life and is applicable to both Secondary and Primary care settings.
The subcutaneous route of medication administration remains the preferred route as patients will often have difficulty or be unable to swallow in the last days of life.

Please seek advice from the local Hospital Specialist Palliative Care team or Hospice if needed:

Belfast HSC Trust	**028 9615 1900**
Northern HSC Trust	**028 9442 4000**
South Eastern HSC Trust	**028 4483 8388 ext 2222**
Southern HSC Trust	**028 3026 7711**
Western HSC Trust (North Sector)	**028 7134 5171 (Altnagelvin Hospital Switchboard)**
Western HSC Trust (South Sector)	**028 6638 2000 (SWAH)**

Details of Palliative Care Network Pharmacies and Palliative Care Supply Service pharmacies (i.e. those with extended opening hours who are contracted to stock the regional palliative care medicines list) can be found at Palliative Care (hscni.net)

STAFF SHOULD BE AWARE THAT THIS GUIDANCE IS SUBJECT TO CHANGE AS DEVELOPMENTS OCCUR. CHECK FOR UPDATES ON THE PALLIATIVE CARE IN PARTNERSHIP WEBSITE www.pcip.hscni.net

For patients who are seriously ill with Covid-19, honest and sensitive conversations about goals of care and treatment escalation planning should be initiated as early as possible.

Action	Consider
Establish a clear ceiling of care at admission DNACPR discussions	N/A
Review route of administration of medicines for symptom control - continue oral if tolerated and prescribe PRN SC alternatives as appropriate	N/A
Consider stopping routine vital observations and interventions including BMs and fluids. If undertaken, these observations and interventions should be to guide symptom management e.g. temperatures and respiratory rates.	Rationalise diabetes treatment and BM monitoring in line with diabetes UK End-of- Life-Care; https://www.diabetes.org.uk/resources-s3/2018-03/EoL_Guidance_2018_Final.pdf Consider stopping fluids
Anticipatory Prescribing	Ensure anticipatory medication is prescribed for all patients - please prescribe oral and SC options as appropriate
Consider mouth care	Consider regular Biotene Gel four times a day Avoid mouthwashes
Rationalise all medicines	Consider stopping non-critical medicines and if necessary, reviewing the route of administration for critical medicines e.g. anti-epileptics, Parkinson's medication
Attend to the social, psychological and spiritual care of the patient as appropriate	Regularly assess the psychological needs of the patient and family. Consider active management strategies to address levels of distress (e.g. surrounding environment)
Communication with those important to the patient	Regular and clear communication with patients and those important to them is essential, including sensitive and compassionate updates regarding changes in the condition of their loved one.

General points

- In all cases consider the benefits of VTE prophylaxis, steroids, prone positioning and other non-pharmacological measures (Seek physio advice if required). Refer to local guidance on management of COVID patients and review ongoing appropriateness of interventions for patients in last days of life.
- For patients already on opioid medications, the breakthrough dose should be one sixth of patient's regular total daily opioid dose.
- For all symptoms, consider **starting at lower end of ranges given, especially in patients who are opioid-naïve, elderly or have a low BMI,** and titrating up rapidly as needed (usually 30-50% every 12 hours, using clinical judgement. Reassess symptoms if patient is not responding).
- For patients who are very symptomatic or distressed, consider starting higher doses in the range and titrating up rapidly if needed. The patients may benefit from a dose range being prescribed to allow nursing staff more flexibility e.g. Morphine Sulfate 2mg-5mg SC PRN (TWO mg to FIVE mg) for pain or dyspnoea 2 hourly to a maximum of 30mg/24hrs PRN.
- A shorter dose interval eg 1-2 hourly PRN with a clear maximum dose in 24hrs may also allow flexibility.
- The patients may deteriorate very quickly and may require combinations of two SC PRNs at one time e.g. if SOB and agitated- consider giving the patient Morphine Sulfate SC for SOB and Midazolam SC for anxiety.
- Consider the use of a subcutaneous syringe pump if repeated stat doses are required for symptom management. Consider using a **subcutaneous line** to allow for stat dosing, particularly if a syringe pump is unavailable or not appropriate and repeated stat doses are required for symptom management. Consider using a 'Saf-T-Intima' for this purpose at end of life.
- Unless stated these drugs are compatible in a CSCI with 0.9% Sodium Chloride. Up to 4 drugs can be added to a CSCI.
- **FOR LOW VOLUME ORAL DRUGS GIVEN e.g. 0.5ml, ENSURE 1 ML ORAL SYRINGES ARE AVAILABLE FOR CARER / PATIENTS.**

	Initiation of therapy	Progression of symptoms
Dyspnoea/Pain/Cough **Consider reversible causes and treat if appropriate. Consider positioning; relaxation techniques; reduce room temperature; cool cloth for face; psychological support. Avoid all fans. Consider cough hygiene ('Catch it/ Bin it/ Kill it') and measures e.g. oral fluids/cough remedies/humidified air.** **For patients already on opioid medications adjust the breakthrough dose to one sixth of the patient's regular total opioid dose.** **Consider oxygen therapy in patients who are hypoxaemic (saturations <90%). Refer to local guidance with respect to steroids.**		
Injectable option	eGFR >45 ml/min Morphine Sulfate injection 2mg-5mg every 2-4 hours PRN by SC Inj eGFR 15-45 ml/min Oxycodone injection 1mg-2mg every 2-4 hours PRN by SC Inj eGFR <15 ml/min or concern re opioid toxicity Oxycodone injection 1mg every 2-4 hours PRN by SC Inj and Contact Specialist Palliative Care Team for advice	eGFR >45 ml/min Morphine Sulfate injection 5mg +/-Midazolam 5mg over 24 hours via CSCI (Continuous Sub-Cutaneous Infusion) and continue PRN SC Inj for breakthrough eGFR 15-45 ml/min Oxycodone injection 3mg +/-Midazolam 5mg over 24 hours via CSCI and continue PRN SC Inj for breakthrough eGFR <15 ml/min or concern re opioid toxicity Oxycodone injection 1mg every 2-4 hours PRN by SC Inj Consider Alfentanil 300 micrograms +/- Midazolam 3mg over 24hrs via CSCI Contact Specialist Palliative Care Team for advice
Non-injectable Alternative	eGFR >45 ml/min Morphine Sulfate Oral Solution (Oramorph®) 5mg every 2-4 hours PRN eGFR 15-45 ml/min Shortec® Oral Solution 1mg-2mg every 2-4 hours PRN eGFR <15 ml/min Shortec® Oral Solution 1mg-2mg every 2-4 hours PRN and Contact Specialist Palliative Care Team for advice	Use available short-acting opioid e.g. Oramorph® or Shortec® at equivalent dose, regularly every 4 hours and 2hourly PRN. Consider use of long-acting opioid at appropriate starting dose according to previous opioid use e.g. MST® BD while continuing Oramorph® PRN OR Longtec® BD while continuing Shortec® PRN. See Regional Opioid Conversion Guidance http://www.professionalpalliativehub.com/resource-centre/northern-ireland-guidelines-converting-doses-opioid-analgesics-adult-use-2018 Contact Specialist Palliative Care Team for advice. eGFR <15 ml/min Please exercise caution if prescribing long-acting opioid medication in patients with renal impairment.

Agitation/Anxiety/Delirium		
Injectable Option	Midazolam injection 2mg-5mg every 2 hours PRN by SC Inj **And either** Levomepromazine 5mg every 4 hours PRN by SC Inj **OR** Haloperidol 0.5mg-1mg every 2 hours PRN by SC Inj	Midazolam 5mg-10mg over 24 hours via CSCI **And add either** Levomepromazine 10mg -25mg over 24 hours via CSCI **OR** Haloperidol 3mg over 24 hours via CSCI and continue PRN SC Inj for breakthrough
Non-injectable Alternative	Lorazepam sublingual tablets 0.5mg - 1mg every 4 hours PRN (Max 4mg/24 hours) (Suitable brands – Genus, Teva, Lexon or Mylan) **OR** Diazepam 2mg-5mg every 4 hours PRN	Haloperidol 0.5mg - 1mg every 4-6 hours PRN **OR** Levomepromazine tablets 6mg-12mg every 4-6 hours PRN (Max TDS)
Respiratory Secretions		
Injectable Option	Glycopyrronium injection 200 micrograms every 4 hours PRN by SC Inj And/or Glycopyrronium injection 600micrograms -1200 micrograms over 24 hours by CSCI (Max dose 1200 micrograms in 24 hours) **OR** Hyoscine Butylbromide injection 20mg every 4 hours PRN by SC Inj And/Or Hyoscine Butylbromide injection 60mg-120mg over 24 hours by CSCI	Hyoscine Hydrobromide injection 400 micrograms every 4 hours PRN by SC Inj And/or Hyoscine Hydrobromide injection 1200 micrograms -2400 micrograms over 24 hours by CSCI NB: First line choice of antisecretory may be affected by availability of medications. Hyoscine Hydrobromide is a potent antimuscarinic which crosses the blood brain barrier. It can be used to add to sedation, but needs to be monitored as can add to agitation.
Pyrexia		
Injectable Option	Can use IV Paracetamol if cannula in situ Dose according to weight: >50kg 1g QDS or every 4-6 hours PRN ≤50Kg 15mg/kg QDS or every 4-6 hours PRN	**NSAIDs may be an option at end of life where there is difficult to control pyrexia and limited alternatives** Consider: Parecoxib injection 20mg BD PRN by SC Inj or 40mg-80mg over 24 hours by CSCI (Parecoxib should not be mixed in syringe pump with any other medicine)
Non-injectable Alternative	Paracetamol Oral tablets 1g QDS or every 4-6 hours PRN Also consider cooling the face using a cool cloth and oral fluids if able. **Avoid** all fans	Paracetamol Suppositories 1g QDS or every 4-6 hours PRN And/Or Diclofenac Suppositories 50mg-100mg every 8 hours PRN (Max 150mg/24 hours)