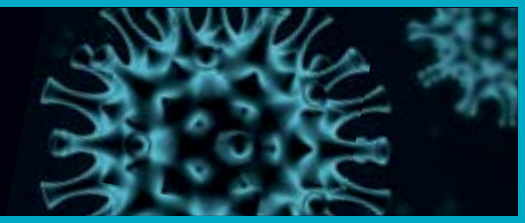
RPMG

Palliative Care in partnership

HSC Public Health Agency

CORONAVIRUS



COVID-19: Symptom Management in Last Days of Life

(For use in Secondary and Primary Care Settings)

(April 2020)

COVID-19: Symptom Management in Last Days of Life (2 April 2020)

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 as a result of COVID-19 pandemic. It is specifically for use in patients in the last days of life **and is applicable in 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. If there are issues with drug availability, please refer to 3rd line options - these should only be considered as a last resort where all other options have been exhausted.

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)**

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	
Review route of administration of medicines for symptom control - continue oral if tolerated and prescribe PRN SC alternatives as appropriate	
Usual SC medicines are not available or cannot be administered	See 3rd line medicine choices
Consider stopping regular observations and inverventions including BMs and fluids	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 parenteral 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	

General points

- In all cases consider positioning and other non-pharmacological measures. Seek physio advice if required.
- For patients already on opioid medications adjust the breakthrough dose to one sixth of the patient's regular total 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 eg 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 permissible dose in 24hrs may also allow flexibility
- The patients may deteriorate very quickly and may require combinations of 2 or 3 SC PRNs at one time eg if SOB/agitated and having secretions - consider giving the patient Morphine Sulfate SC for SOB; Midazolam SC for anxiety and a SC antisecretory.
- Consider using a **subcutaneous line** to allow for stat dosing, particularly if repeated stat doses are required for symptoms. 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 SYRINGES ARE AVAILABLE FOR CARER / PATIENTS.**

For use in Secondary and Primary Care

	1st line – Initiation of therapy	2nd line – Alternative or 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 eg 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.***		
Injectable option	**eGFR>45** Morphine Sulfate injection 2mg-5mg every 2-4 hours PRN by SC Inj **eGFR15-45** Oxycodone injection 1mg-2mg every 2-4 hours PRN by SC Inj **eGFR<15or 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** Morphine Sulfate injection 10mg +/-Midazolam 10mg over 24 hours via CSCI (Continuous Sub-Cutaneous Infusion) and continue PRN SC Inj for breakthrough **eGFR15-45** Oxycodone injection 5mg +/-Midazolam 10mg over 24 hours via CSCI and continue PRN SC Inj for breakthrough **eGFR<15or concern re opioid toxicity** Oxycodone injection 1mg every 2-4 hours PRN by SC Inj Consider Alfentanil 1mg +/- Midazolam 5mg-10mg over 24hrs via CSCI Contact Specialist Palliative Care Team for advice
Non-injectable Alternative	**eGFR>45** Morphine Sulfate Oral Solution (Oramorph®) 5mg every 2-4 hours PRN **eGFR15-45** Shortec® Oral Solution 1mg-2mg every 2-4 hours PRN **eGFR<15** Shortec® Oral Solution 1mg-2mg every 2-4 hours PRN and Contact Specialist Palliative Care Team for advice	Use available short-acting opioid eg 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 eg 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 Please exercise caution if prescribing long-acting opioid medication in patients with renal impairment.

Delirium/Agitation/ Anxiety ***Consider reversible causes and treat if appropriate. eg: superadded infection; drugs; urinary retention; dehydration; constipation; hypoxia. Consider usual non-pharmacological approaches.***		
Injectable option	Midazolam injection 2mg-5mg every 2 hours PRN by SC Inj **And either** Haloperidol 0.5mg-1mg every 2 hours PRN by SC Inj **OR** Levomepromazine 5mg-10mg every 4 hours PRN by SC Inj	Midazolam 10mg over 24 hours via CSCI **And add either** Levomepromazine 10-25mg **OR** Haloperidol 3-5mgand continue PRN SC Inj for breakthrough
Non-injectable Alternative	Lorazepam sublingual tablets 0.5-1mg every 4 hours PRN (Max 4mg/24 hours) (Suitable brands – Genus, Teva, Lexon or Mylan) **OR** Diazepam 2mg-5mg every 4 hours PRN	Haloperidol 0.5-1mg every 4-6 hours PRN **OR** Levomepromazine tablets 6mg-12mg every 4-6 hours PRN (Max TDS) (25mg tablets can be used and split to appropriate dose and dissolved in water if 6mg tablets are unavailable)
Respiratory Secretions ***Consider repositioning on side or semi-prone position; reassurance of family that secretions are not likely to be causing the patient discomfort.***		
Injectable option	Glycopyrronium injection 200 micrograms every 4 hours PRN by SC Inj **and/or** Glycopyrronium injection 600-1200 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 60-120mg over 24 hours by CSCI	Hyoscine Hydrobromide injection 400 micrograms every 4 hours PRN by SC Inj **and/or** Hyoscine Hydrobromide injection 1200-2400 micrograms over 24 hours by CSCI NB: First line choice of antisecretory may be affected by availability of medications.
Non-injectable Alternative	Hyoscine Hydrobromide sublingual tablets (Kwells®) 300 micrograms every 6 hours PRN (Max 3 doses/24 hours)	Hyoscine Hydrobromide 1mg Patch (Scopoderm®) every 72 hours

Pyrexia ***Consider cool cloth for face; oral fluids if able. Avoid all fans.***		
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 are NOT recommended in COVID-19 but 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 40-80mg 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 50-100mg every 8 hours PRN (Max 150mg/24 hours)

3rd line medicine choices

To be used only if 1st and 2nd line choices are not suitable or not available. These are considered less well established practice.

Exercise caution when prescribing as may lead to an increased risk of adverse events.
Note: Transdermal preparations may be absorbed more rapidly in pyrexic patients

Product	Prescribing details
Dyspnoea/Pain	
Buprenorphine Patch* – BuTec®	10-20 microgram/hour every 7 days (NB Equivalent to 20-50mg Oral Morphine/24 hours)
Fentanyl Patch* – Mezolar Matrix®	12-25 microgram/hour every 72 hours (NB Equivalent to 30-90mg Oral Morphine/24 hours)
Oramorph® CONCENTRATED 20mg/ml Oral Solution	10mg every 4 hours via buccal route PRN **(NB 0.5ml volume – high risk of overdose if inaccurate measure)**
Shortec® CONCENTRATED 10mg/ml Oral Solution	5mg every 4 hours via buccal route PRN **(NB 0.5ml volume – high risk of overdose if inaccurate measure)**
Agitation/Anxiety/Delirium	
Epistatus® Buccal Solution OR Buccolam®Prefilled Syringes (in the absence of the above being available, midazolam solution for injection can be administered via buccal mucosa)	5-10mg every 4 hours PRN via buccal administration
Diazepam Enema	5-10mg OD PRN via rectum
Olanzapine Orodispersible tablets	5-10mg OD (Can increase to 20mg/day as required)
Risperidone tablets	500 micrograms BD regularly or PRN
If CSCI not available but DN able to administer SC injection:	Consider Haloperidol 1-3mg sc daily or Levomepromazine 10mg sc od /bd
Respiratory Secretions	
If CSCI not available but DN able to administer SC injection:	Consider Hyoscine Butylbromide 40mg SC BD **OR** Glycopyrronium 400mcg BD or TID
Atropine 1% Eye Drops	Sublingually 1-2 drops every 6-8 hours PRN

*Note topical opioid patches will take 24-48 hours to establish efficacy in most patients and PRN opioids/alternative strategies will need to be used in meantime.

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This guidance has been prepared by the Regional Palliative Medicine Group (RPMG) in Northern Ireland with input from the NI Specialist Palliative Care Pharmacy Group and supported by the Palliative Care in Partnership Programme.

WE ALL MUST DO IT TO GET THROUGH IT