Clinical guidelines for symptom control in patients with Covid-19 (2 pages)

In **acute phase of** COVID-19,it is important patients have their symptoms controlled **alongside** active medical treatment.
NB Opioid and benzodiazepine use in palliation should not be withheld because of fear of causing respiratory depression.
For all Covid-19 patients, please ensure the following symptoms are considered and **prn**/regular medication prescribed:

SD =syringe driver **sc** =subcutaneous **MR** =modified release **IR** =immediate release **SL**=Sublingual **TDD**= total daily dose

Symptom	Clinical indication	Recommendation
	Opioid naïve (no previous opioids) and able to swallow	1st line Morphine sulphate MR (modified release) oral 5 mg 12 hourly and increase as necessary to 15mg 12 hourly (**Max** 30mg/24 hours) **NB** If eGFR <30 mL/min oral oxycodone MR 5mg 12 hourly
		Alternative Morphine sulphate IR (immediate release)oral 2 to 5mg 2 to 4 hourly **prn** **NB** If eGFR <30 mL/min Oxycodone IR oral 1 to 2 mg 2 to 4 hourly **prn**
	Patients on regular opioids for pain relief	Morphine sulphate IR oral 2 to 5mg 2 to 4 hourly **prn** or one twelfth of the 24 hour dose for pain, whichever is greater. **NB** If eGFR <30 mL/min Oral oxycodone IR 1 to 2 mg 2 to 4 hourly **prn**
	Patients who are **unable to swallow** use subcutaneous(sc) medications	Morphine sulphate 2mg sc 2 to 4 hourly **prn** If > 2 doses required per day, consider a syringe driver (**SD**) Starting dose morphine sulphate 10mg/24hour **NB** If eGFR <30 mL/min Oxycodone 1 to 2 mg sc 2 to 4 hourly **prn** If > 2 doses use a **SD** Oxycodone 5mg/24 hour *If already on regular opioids (oral or transdermal) refer to conversion charts on 'Anticipatory Drugs and Syringe Driver Chart' and note the advice above: 'Patients who are on regular opioids for pain relief'*
Anxiety	Patients who can swallow	Lorazepam 500micrograms to 1mg **SL** 2 to 4 hourly **prn** **Max** 4mg/24 hours
	Patients **unable to swallow**	Midazolam 2 to 5mg sc 2 to 4 hourly **prn** If > 2 doses required daily, consider a syringe driver Starting dose **SD** Midazolam 10mg/24hour **Max** 30mg/24hours **NB** If eGFR <30mL/min reduce starting dose **SD** Midazolam 5mg/24hr
Cough	Opioid naïve	**1st line** Simple linctus 5mL qds **2nd line** Opioids dosing as for breathlessness see above
Fever		Regular antipyretics such as paracetamol (avoid NSAIDs and use of fan)
Delirium	Potentially reversible	*Pharmacological measures only indicated in severe delirium with distressing hallucinations or severe agitation.* Haloperidol 500micrograms to 1mg oral /sc **stat.** Observe for 30 to 60 minutes Repeat if necessary and thereafter 8 hourly **prn**. **Max** 5mg/24 hours
		2nd Line (**1st line** in Parkinson's Disease) Lorazepam 500microgram to 1mg **SL** 2 to 4 hourly **Max** 4mg/24 hour Be aware that benzodiazepines may increase levels of confusion
	Irreversible terminal delirium/agitation not expected to recover. Patient is dying	**1st line** Midazolam 2 to 5 mg sc 2 to 4 hourly **prn** If > 2 doses required daily, consider a **SD** Starting dose **SD** Midazolam 10mg/24hour **Max** 60mg/24hours **NB** If eGFR <30 mL/min **SD** Midazolam to 5mg/24 hour **Max** 30mg/24hours
	Seek advice from palliative care if using 2nd line as doses may need to be escalated rapidly	**2nd line** Levomepromazine or Haloperidol and continue midazolam **SD** Levomepromazine12.5mg to 25mg sc 4 hourly **prn SD** 25mg/24hour **Max** 100mg/24hr **NB** If eGFR <30 mL/min or elderly use lower starting doses Levomepromazine 6.25mg to 12.5mg sc 4 hourly **prn SD** 12.5mg/24hr **OR** Haloperidol 500micrograms to 1mg sc 2 to 4 hourly **prn** **SD** 3 mg over 24 hour **Max** 5mg/24 hour
Pain	Use WHO analgesic ladder	Step 1 Paracetamol, Step 2 weak opioids Step 3 morphine IR 2 to 5mg 2 to 4 hourly and titrate Convert to morphine MR. **prn dose** is total daily dose(**TDD**)divided by 6 If eGFR <30 mL/min use oxycodone IR 1 to 2mg (2x strong as morphine)
	Conversions for a SD sc prn dose =**TDD**/6	Oral morphine to sc morphine divide by 2 Oral oxycodone to sc oxycodone divide by 2 If on a transdermal patch keep in situ and top up with sc inj and/ or a **SD**

NB If starting a regular opioid, then consider starting a prn laxative (e.g. Laxido 1 to 2 sachets bd **prn** or picosulphate 5 to 10mL od **prn**) and antiemetic (e.g. haloperidol 500micrograms to 1mg oral/sc 8 hourly **prn**)
If a patient **rapidly deteriorates despite active management** then please follow the **last days of life documentation**.

Non-pharmacological symptom control in patients with Covid-19

Use of non-drug symptom management strategies can help relieve symptoms and reduce reliance on medications
Generally non-drug approaches to symptom management are preferred, particularly for mild to moderate symptoms

Symptom	Non-pharmacological measures
Breathlessness (at rest or minimal exertion)	• Positioning (Sit upright, legs uncrossed, let shoulders droop, keep head up; lean forward) • Relaxation techniques • Reduce room temperature • Cooling the face by using a cool flannel or cloth • Reassurance • Avoid portable fans due to infection control risk in COVID-19
Anxiety	• Facilitate expression of emotions • Explore fears and concerns • Address spiritual or religious needs • Distraction – e.g. playing music or radio • Offer reassurance
Cough	• Suck on menthol sweets (e.g. Fisherman's friend) • Humidify room air • Oral fluids • Elevate the head when sleeping
Fever	• Reduce room temperature • Wear loose clothing • Cooling the face by using a cool flannel or cloth • Oral fluids • Avoid portable fans as infection control risk
Delirium	**Check for reversible causes** • Infection • Electrolyte disturbance • Dehydration • Hypoxia • Hyper/hypoglycaemia • Urinary retention • Constipation • Pain • Medication related • Medication or alcohol withdrawal
	• Reorient (explain where they are, who you are etc) and reassure • Ensure lighting levels mimic the time of day • Ensure the patient has access to glasses and hearing aid if applicable • If family members can be present involve them in reassuring patient • Ensure continuity of care by staff known to patient where possible • Avoid moving people within and between wards or rooms unless absolutely necessary
Agitation/ Terminal restlessness	**Check for reversible causes:** • Urinary retention • Constipation • Pain – remember to check both syringe driver functioning correctly and skin site
	• Repositioning • Reassurance • Calm surrounding environment

If you require **advice, please contact the Specialist Palliative Care Team directly on the numbers below**

York Specialist Palliative Care team (SPCT)		Scarborough Specialist Palliative Care team (SPCT)	
In hours	• Community SPCT 01904 777770 • Hospital SPCT 01904 725835 • St Leonard's Hospice 01904 708553	**In hours**	• Community SPCT 01723 356043 • Hospital SPCT 01723 342446 • St Catherine's Hospice 01723 351421
Out of hours	• GP OOH 0300 1231 183 • St Leonard's Hospice 01904 708553	**Out of hours**	• GP OOH NHS 111 • Palcall 01723 354506
Community nursing	•Single point of access (SPA) 01904 721200	**Community nursing**	•S&R Community Services (CAS) 01653 609609

There is always access to a consultant on call via your local hospice

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Saint Catherine's
Caring for you at Hospice and Home

St Leonard's Hospice
Caring for Local People

NHS
York Teaching Hospital
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