NHS
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Palliative Care for Patients in Hospital with COVID-19 infection

Introduction

- Patients who are in hospital with COVID-19 infection are likely to have severe rather than mild or moderate disease
- For older patients in hospital, particularly those over 80 with other illness (cardiovascular, respiratory, diabetes), the illness is likely to be more severe and their chance of dying is high even with improved understanding of treatment options.
- The illness can change quickly to severe or critical, so understanding patient wishes regarding treatment is important

Communication

- Patients and families/carers are likely to be frightened as to what will happen. Speak calmly, clearly and honestly
- Give reassurance that you will do everything possible to help them feel comfortable and get specialist advice as needed
- Be honest that the patient is ill enough to die, but all possible supportive treatment will be given and giving medication for symptom management will not shorten life. When a patient is dying, treating symptoms is a major priority
- Explain your plan to patient/family/colleagues and document clearly in notes. Ensure DNACPR/TEP forms are completed

Prescribing

- Symptoms may start and progress rapidly; do not wait until a patient has symptoms to prescribe anticipatory medication
- Only give medication to patients who have symptoms, but give it at the first sign of symptom distress
- Contact specialist palliative care team for advice especially if patient is on regular opioid medication or if frequent 'as required' (PRN) doses are need for symptom relief
- Ensure that medication for PRN use for symptoms is prescribed as well as regular medication

Anticipatory medication

- Main expected symptoms from COVID-19 are breathlessness, cough, agitation/delirium and pain
- Oral morphine liquid and sublingual lorazepam can be used to manage breathlessness and pain in many patients
- The anticipatory prescribing sets already on ePMA can be used for patients who are unable to manage oral medication
    - Normal renal function – morphine, midazolam, levomepromazine, hyoscine butylbromide
    - Reduced renal function – alfentanil, midazolam, levomepromazine, hyoscine butylbromide
- If a second dose of PRN medication is needed in 24 hours for one symptom, start regular medication for that symptom
- If parenteral medication is indicated but not available or able to be administered, please contact specialist palliative care team for advice re alternative treatment options
- For management of symptoms other than those listed overleaf please see CDDFT Care for the Dying Patient guidance: http://intranet/sites/cch-palcare/End%20of%20life%20Information/Guidance;%20Caring%20for%20the%20dying%20patient-2020.pdf

Supplementary oxygen at end of life

- Consider supplementary oxygen if the patient is hypoxic – using at a rate that provides comfort
- For patients using supplementary oxygen the flow rate maybe high
- As there is good evidence for the use of opioids in the management of breathlessness, a decision may be made with the patient and their family to focus on symptom management with opioids and benzodiazepines
- There is a possibility that supplementary oxygen may prolong the dying phase of a patient's life
- When patients are dying their oxygen saturations (and other observations) will no longer guide you as to the effectiveness of the oxygen. Routine observations including oxygen saturations should be discontinued
- If oxygen appears to be providing comfort it can be continued but you may be able to wean it down guided by symptoms
- If oxygen therapy appears to be causing distress it can be stopped. The focus of care is comfort
- If symptoms are being controlled through other means it is ok to try to wean the oxygen off

Palliative care advice Monday – Friday 09:00 – 17:00hours:
Specialist Palliative Care Team (DMH and BAH) 01325 743336, if urgent please contact the team via switchboard
Specialist Palliative Care Team (UHND) – 0191 3332338, if urgent please contact the team via switchboard
Out of hours Monday – Friday 17:00 – 09:00hours, weekend and bank holidays 24hour: 07917 581089

Adapted from;
Association for Palliative Medicine: COVID-19 and Palliative, End of Life and Bereavement Care in Secondary Care
https://apmonline.org/wp-content/uploads/2020/04/COVID-19-and-Palliative-End-of-Life-and-Bereavement-Care-20-April-2020-2.pdf
Northern England Clinical Networks: Palliative and End of Life Care Guidelines
http://www.northerncanceralliance.nhs.uk/wp-content/uploads/2018/11/NECNXPALLIATIVEXCAREX2016.pdf

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Symptom management

Symptom	*Non-pharmacological*/pharmacological management
Breathlessness	• Reposition e.g. sit upright, uncross legs, lean forward, let shoulders droop • Reduce room temperature, cool face with flannel or cloth • Portable fans are *NOT* recommended in infection outbreaks
	• **Oxygen** if hypoxaemia and able to tolerate • **Opioids** may reduce perception of breathlessness e.g. oral morphine 2.5-5mg 1-2 hourly PRN; morphine 2.5mg SC 1-2 hourly PRN if unable to swallow. Consider regular oral morphine MR 5-10mg BD if ongoing breathlessness or frequent administration of PRN meds is not desirable. • **Anxiolytics** for associated anxiety e.g. lorazepam 500 micrograms SL 1 hourly PRN or midazolam 2.5-5mg SC 1-2 hourly if unable to swallow • In last days of life, consider morphine 10mg AND/OR midazolam 10mg over 24 hours via syringe driver (suggested starting doses for opioid naïve patients; acutely distressed patients may need higher starting doses e.g. morphine 20mg and midazolam 20mg/24h)
Cough	• Ensure nose/mouth are covered when coughing where possible, dispose of tissues promptly into a clinical waste bin and wash/clean hands • Oral fluids; honey and lemon in warm water; suck cough drops or hard sweets if able • Avoid smoking
	• Prescribe **morphine oral solution** 2.5mg 4 hourly
Pyrexia (fever)	• Reduce room temperature, wear loose clothing • Cool face using a cool flannel or cloth, oral fluids, avoid alcohol • Portable fans are *NOT* recommended for use in infection outbreaks
	• **Paracetamol** 1g PO/PR/IV qds (Reduce dose if weight <50kg, severe renal impairment, frail) • Current advice is that NSAIDS should be prescribed at the lowest dose and for the shortest possible time if indicated for use
Agitation and delirium	• Identify and manage underlying cause where possible • Ensure calm effective communication • Familiar environment and carers present (e.g. family, regular carers) if possible
	• **First line – restlessness/agitation predominant: lorazepam** 500 micrograms SL 1-2 hourly PRN or **midazolam** 2.5-5mg SC 1-2 hourly if unable to swallow • **First line – delirium predominant: levomepromazine** 12.5mg SC 1-2 hourly PRN • **Second line: Midazolam** 10-30mg/24h **AND/OR levomepromazine** 25mg SC/24h (12.5mg/24h in frail elderly) via syringe driver (suggested starting doses) • **Seek advice from specialist palliative care team if patient remains distressed or if more than 2 doses of PRN medication have been needed in 24 hours**
Secretions	• Repositioning of patient • Consider stopping parenteral fluids
	• **Hyoscine butylbromide** 20mg SC 1-2 hourly PRN max 6 doses in 24h • If 2 doses needed in 24 hours start syringe driver with 60mg/24h
Pain (due to pre-existing condition, cough or immobility)	• **Step 1**: If on no analgesics and has mild pain, start **paracetamol** 1g QDS • **Step 2**: If pain persists/worse, replace paracetamol/add in **regular codeine** 30-60mg QDS • **Step 3**: If pain persists or worsens despite codeine +/- paracetamol, **stop codeine** and **use strong opioid** e.g. oral morphine
	• **Suggested starting doses if opioid naïve** – morphine MR 10-20mg BD (10mg BD in frail elderly) • **If previously using weak opioid (e.g. codeine 240mg in 24h/co-codamol 30/500 2 tabs qds)** use morphine MR 20-30mg BD (10-15mg BD if frail elderly) • **Always prescribe additional immediate release opioid for PRN use** at 1/6th total 24h dose • **Monitor patient for side effects; always prescribe laxatives alongside strong opioids** • **If effective, dose can be adjusted taking PRN doses into account**; however increments should not exceed 33-50% every 24 hours • **If patient has renal failure (eGFR <30), phone specialist palliative care team for advice** • I**f oral route is not available, consider initiating subcutaneous opioids**