**Two page guide** 

**Pharmacological measures**

Due to the rapid progress of symptoms associated with severe COVID-19 disease, use of prn medication is first line (prioritising syringe drivers (CSCI) for existing palliative care patients. **Please consider when prescribing.**

**Breathlessness – mild to moderate**

* opioids may reduce the perception of breathlessness
  + morphine modified release 5mg po bd (titrate up to maximum 30mg daily according to need)
  + morphine 2.5-5mg po prn to 2-4 hourly (1-2mg sc 2-4 hourly if unable to swallow)
  + lorazepam 0.5mg sl prn to 4 hourly *or* midazolam 2.5-5mg sc prn to 2-4 hourly for associated agitation or distress
  + **in the last days of life**
    - morphine 2.5-5mg SC prn to 1-2 hourly *and / or* midazolam 2.5mg sc prn to 1-2 hourly
    - consider morphine 10mg *and / or* midazolam 10mg over 24 hours via syringe driver, increasing to morphine 30mg / midazolam 60mg step-wise as required (advice from palliative care recommended)

**Breathlessness – severe (akin to ARDS scenarios)**

* morphine 5-10mg sc prn to 2 hourly (oxycodone 2.5-5mg sc prn to 2hourly if low eGFR)
* midazolam 5-10mg sc prn to 2-4 hourly (may need in some cases to be hourly)
* consider morphine 10-20mg and / or midazolam 10-20mg over 24 hours via syringe driver
* syringe driver dosing may need to be reviewed 8-hourly rather than every 24 hours if the patient’s prn requirements are escalating rapidly without control of their symptoms
* dosing requirements may not ‘fit’ with established practice and may have to be determined on a case by case basis – always prescribe safely, but also in line with your patients’ requirements

**Cough**

* simple linctus 5-10mg po qds *then* codeine linctus 30-60mg po qds *or* morphine sulphate immediate release solution 2.5mg po 4 hourly
* **if severe / end of life:** morphine sulphate 10mg CSCI / 24 hours and 2.5–5mg sc prn to 1-2 hourly

**Delirium**

* **First line:**
  + haloperidol 500 microgram / 24h CSCI or po/sc at bedtime and prn to 2 hourly
  + consider a higher starting dose (1.5-3mg po/sc) in severe distress
  + lorazepam 500 micrograms-1mg po bd and prn *or*midazolam 2.5-5mg sc prn to 1-2 hourly
* **End of life (last days / hours):**
  + use a combination of levomepromazine (delirium) and midazolam (anxiety) in a syringe driver
  + **levomepromazine** 25mg sc stat & prn to 1 hourly (12.5mg in elderly); titrate according to response
    - maintain with 50-200mg / 24h CSCI (must start low and titrate according to need; seek advice)
    - alternatively, smaller doses given as an sc bolus at bedtime, bd and prn
  + **midazolam** 2.5-5mg sc/iv stat and prn to 1 hourly
    - if necessary, increase progressively to 10mg sc/iv prn to 1 hourly
    - maintain with 10-60mg / 24h CSCI (must start low and titrate according to need; seek advice)

**Fever**

paracetamol 1g PO / IV / PR QDS (**\*\*NSAIDS should be used with caution in COVID-19\*\***) (NHSE, 2020)

* but at end of life could consider NSAIDs (e.g. parecoxib 40mg sc od/bd)

**Respiratory secretions**

* options:
  + glycopyrronium 200-400 micrograms sc stat / prn to 2 hourly & CSCI 600-1200mcg over 24 hours
  + hyoscine butylbromide 20mg sc stat / prn to 6 hourly & CSCI 20-120mg over 24 hours
  + hyoscine hydrobromide 400 micrograms sc stat / prn to 6 hourly & CSCI 1200-2400 mcg over 24 hours

**Non-pharmacological measures**

**Reversible causes**

* both COVID-19 and non-COVID-19 conditions (advanced lung cancer, SVCO, lymphangitis carcinomatosis, etc) ***may*** cause severe distress / breathlessness toward end of life
* check blood oxygen levels

**Cough**

* humidify room air
* oral fluids
* honey & lemon in warm water
* suck cough drops / hard sweets
* elevate the head when sleeping
* avoid smoking

**Breathlessness**

* + positioning (various advice depending on position: 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
* portable fans used in clinical areas have been linked to cross infection in health and social care facilities, although there is no strong evidence yet
* portable fans are not recommended for use during outbreaks of infection or when a patient is known or suspected to have an infectious agent

**Delirium**

* identify and manage the possible underlying cause or combination of causes
* ensure effective communication and reorientation (for example explaining where the person is, who they are, and what your role is) and provide reassurance for people diagnosed with delirium
* consider involving family, friends and carers to help with this
* ensure that people at risk of delirium are cared for by a team of healthcare professionals who are familiar to the person at risk
* avoid moving people within and between wards or rooms unless absolutely necessary
* ensure adequate lighting

**Fever**

* reduce room temperature
* wear loose clothing
* cooling the face by using a cool flannel or cloth
* oral fluids
* avoid alcohol
* portable fans used in clinical areas have been linked to cross infection in health and social care facilities, although there is no strong evidence yet
* portable fans are not recommended for use during outbreaks of infection or when a patient is known or suspected to have an infectious agent

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