NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

In-hospital palliative care in Covid-19 disease –

guidance for general medicine

adapted from NHS England Specialty guides for patient management during the coronavirus pandemic
Clinical guide for the management of palliative care in hospital 27 March 2020, Version 1.

Royal Derby Hospital: Hospital Palliative Care Team on #6180 in office hours. If needed, the Palliative Medicine Consultants can be contacted via secretaries on ext 88794.

Queen's Hospital Burton: Hospital Palliative Care Team on ext 5034; they will locate an available consultant.

Out of hours for all sites call switchboard, ask for palliative medicine consultant on call.

My patient does not have COVID-19 but is recognised to be dying → Usual symptom management guidance applies. https://derbyshire.eolcare.uk/content/documents/uploads/toolkit-docs/Symptom-Management-EOL-Guidance-update-2020-1.pdf

My patient has COVID-19 or suspected COVID-19

- They are not recognised to be dying but they have symptoms related to COVID-19
  - Is my patient receiving appropriate supportive treatments?
  - Have correctable causes of symptoms been considered and managed appropriately?
  - *Examples include:*
    - *Antibiotic treatment for a superadded bacterial infection which may improve fever, cough, breathlessness and delirium*
    - *Optimising treatment of comorbidities (e.g. chronic obstructive airways disease, heart failure) which may improve cough and breathlessness.*
  - → Go to Pages 2-3 **Management of common symptoms experienced in covid-19**
- They are recognised to be dying but they have no symptoms
  - Prescribe anticipatory prn medication
  - At RDH use icm order set: PALLIATIVE MEDICATIONS (COVID-19) **STEP 2 drugs**
  - At QHB use Meditech order set for end of life care with COVID-19
- They are recognised to be dying and they are distressed with agitation and breathlessness
  - Go to Page 4
  - **Guideline for the symptomatic management of actively dying patients with presumed COVID-19:**
  - **Severe breathlessness & agitation**

ALL PATIENTS SHOULD HAVE A RESPECT FORM COMPLETED

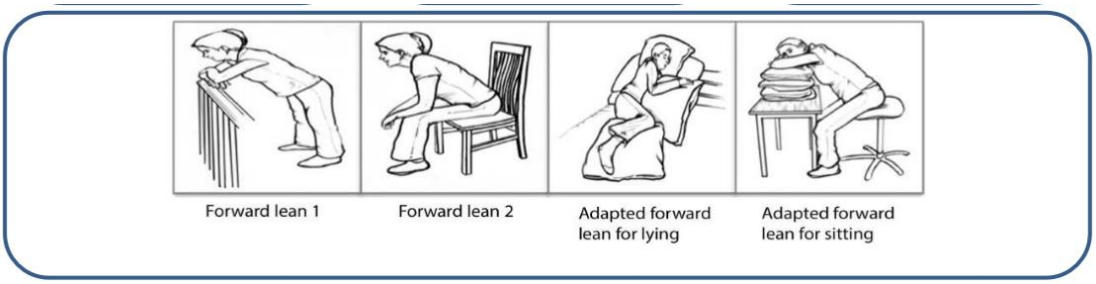
If in any doubt, or for patients with uncontrolled symptoms contact the specialist palliative care team for advice

Management of common symptoms experienced in COVID-19

Breathlessness

Non drug measures:

Different positions may be helpful



Reduce room temperature
Cool the face by using a cool flannel or cloth
Portable fans are not recommended for use during outbreaks of infection
Only if hypoxic – humidified oxygen

Drug treatment:

If patient can manage oral medication:
Morphine modified release initially 5mg bd – usual maximum 30mg daily
AND oramorph 2.5-5mg when necessary (prn); frequency 2 hourly
Consider also lorazepam 0.5mg sublingual when necessary (prn); frequency 2 hourly

If patient cannot manage oral medication use a parenteral opioid *and* a sedative anxiolytic:

- If opioid naïve:
  - give a stat dose of **morphine** 5mg OR **diamorphine** 5mg + **midazolam** 5mg SC (2.5mg in the elderly)
  - start **diamorphine** 10mg/24h + **midazolam** 10mg/24h by CSCI
  - prescribe **morphine** 5mg OR **diamorphine** 5mg + **midazolam** 5mg SC when necessary (prn); frequency 1 hourly (both 2.5mg in the elderly)
- Review regularly and titrate both prn and regular doses to obtain satisfactory relief – seek advice if your patient is distressed

If already taking PO **morphine** or another opioid convert to the equivalent parenteral 24h and prn doses: see https://derbyshire.eolcare.uk/content/documents/uploads/toolkit-docs/Symptom-Management-EOL-Guidance-update-2020-1.pdf
Consider a 25-33% increase in dose from baseline to manage current symptoms

In renal or hepatic failure, alternate opioids may be preferable, contact the palliative care team

Ensure patients receiving regular opiates are considered for laxatives eg senna and docusate

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Cough (without significant breathlessness)

Non drug measures:
Oral fluids

Drug treatment:
A strong opioid is the most effective cough suppressant. If already on **morphine** for breathlessness, this may suffice. Otherwise:

If patient can manage oral medication
Oramorph 2.5mg PO 4 hourly regularly

If patient cannot manage oral medication use a parenteral opioid:

- If opioid naïve:
  - give a stat dose of **morphine** 5mg SC OR **diamorphine** 5mg SC (2.5mg in the elderly)
  - start **diamorphine** 10mg/24h by CSCI
  - prescribe **morphine** 5mg OR **diamorphine** 5mg SC when necessary (prn); frequency 1 hourly (both 2.5mg in the elderly)
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Fever

Non drug measures:
Reduce room temperature
Cool the face by using a cool flannel or cloth
Portable fans are not recommended for use during outbreaks of infection

Drug treatment:

- **paracetamol** 1G PO/IV q.d.s. (500mg when ≤50kg)
- Concerns about NSAIDs are irrelevant if the patient is believed to be dying.

Delirium (mild to moderate – if severe see p4)

Non drug measures:
Usual management of delirium eg reorientate, reassure, lighting, treat reversible causes

Drug treatment:
Haloperidol 500mcg-1mg SC/PO and titrate in 500 microgram increments
Consider a higher starting dose if patient's distress is severe or there is a danger to self/others

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At Burton Hospital use end of life medication set specifically for COVID-19 patients on Meditech

At RDH use icm order set: PALLIATIVE MEDICATIONS (COVID-19)

RDH guideline for the symptomatic management of actively dying patients with presumed COVID-19: Severe breathlessness & agitation

**** All drugs are given subcutaneously****

Step 1:

Diamorphine 5mg *OR* Morphine 5mg
AND
Midazolam 5mg
AND
If severely agitated or delirious add: Levomepromazine 12.5mg *OR* Haloperidol 3mg

Step 2:

Prescribe the same 3 drugs prn
If no effect after 30 minutes they should be repeated
If patient remains unsettled after 1 hour in spite of repeated dosing call palliative care for advice

Step 3:

Prescribe a syringe driver as the patient may survive long enough to benefit:
Over 24hrs:
Diamorphine 10mg, Midazolam 30mg, Levomepromazine 50mg
OR
Diamorphine 10mg, Midazolam 30mg, Haloperidol 10mg

Notes:

- Experience is that when death from COVID-19 occurs it happens quickly
- This guideline (page 4) is for patients **actively dying (believed to be in their last hours of life)** of COVID-19 irrespective of age, frailty or co-morbidities **who are overtly symptomatic.**
- Some patients die of COVID-19 without symptoms. Use clinical judgement to determine what is necessary. Guidance for mild/moderate symptoms, or if survival is anticipated, is given in the first part of this document.
- The on-call palliative care consultant is contacted via switchboard for advice 24/7

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