End of Life Symptom Management Guidelines During COVID 19
(Including medicines avoiding s/c route)

A moist mouth and regular mouth care is important for maximal benefit when using sublingual and buccal preparations – please ensure regular oral hygiene, keeping the mouth moist with water, ice chips and gently brushing with a soft toothbrush where able.

Breathlessness		
	Standard Practice	Alternative
Opioid naïve (i.e. no previous opioids) and able to swallow	Morphine sulphate solution (10mg/5ml) 2.5mg PO 2 to 4 hourly PRN Morphine MR tablets 5mg BD if needed regularly. In renal impairment: Oxycodone 1.25mg to 2.5mg PO hourly PRN (oral Oxycodone solution 5mg/5ml).	
Patients who are unable to swallow	Morphine Sulphate injection 2.5mg SC Hourly PRN Morphine 5mg to 10mg /24 if required in a syringe driver	Concentrated oral Morphine (Oramorph concentrated solution 20mg/1ml®)can be used sublingually: -This as a last resort if nothing else available. - Some evidence of effect - Beware concerns as significant impact to over or under dose. - to aid identification the concentrated solution is RED in colour - 2mg = 0.1mls

		Or if unable to tolerate morphine/renal impairment present Concentrated Oxycodone (OxyNorm® Concentrate 10mg/ml oral solution)can be used sublingually: - This as a last resort if nothing else available. - Some evidence of effect - Beware concerns as significant impact to over or under dose. - to aid identification the concentrate solution is ORANGE in colour - 1mg = 0.1mls
If there is a strong anxiety component	Lorazepam 0.5mg PO/SL PRN QDS up to 4mg in 24 hours Midazolam 2.5mg to 5mg SC 1 to 2 hourly PRN SC Consider a syringe driver with 10mg to 20mg of Midazolam/24hrs	Buccal Midazolam (Buccolam®) 2.5mg prefilled oral syringes. 2.5mg 2 hourly PRN
Cough		
Clinical Indication	Standard Practice	Alternative
	Simple linctus-5mls QDS If ineffective: Codeine linctus 30-60mg QDS	Morphine Sulphate solution (10mg/5ml) 2.5mg to 5mg 4 hourly if opioid naïve Or 5mg to 10mg 4 hourly if switching from codeine.

Fever		
	Standard Practice	Alternative
Consider non-pharmacological methods	Paracetamol 1g PO QDS max 4g/24hrs	Paracetamol suppositories 1g QDS PRN max 4g/24hrs
NSAIDS currently not recommended for use in suspected or confirmed Covid-19 however if patient in last days of life and required	Naproxen 500mg BD or Ibuprofen 400mg TDS	Diclofenac suppositories 50mg TDS
Anxiety, agitation and restlessness		
	Standard Practice	Alternative
Patients who are able to swallow	Lorazepam 0.5mg PO/SL PRN QDS up to 4mg in 24 hours	Olanzapine orodispersible tablets 5mg, 2.5 to 5mg (1/2 to one tablet) ON (can be increased to BD if needed, max 10mg/24 hours)
Patients who are unable to swallow	Midazolam 2.5 to 5mg SC 1 to 2 hourly PRN SC Consider a syringe driver with 10 to 20mg of Midazolam/24hrs	Buccal midazolam (Buccolam®) 2.5mg 2 hourly PRN
Delirium		

Clinical Indication	Standard Practice	Alternative
Patients who are able to swallow	Haloperidol 1mg PO TDS with 0.5mg TDS PRN Haloperidol 1mg SC TDS with 0.5mg TDS 6 hourly PRN	Olanzapine tablets 2.5mg, 2.5 to 5mg OD (Can be increased to BD if needed, max 10mg/24 hours).
Patients who are unable to swallow	Levomepromazine 12.5mg SC Nocte (Levomepromazine can last up to 24 hours) Levomepromazine 12.5mg to 25mg/24hrs in a syringe driver	Olanzapine orodispersible tablets 5mg, 2.5 to 5mg (1/2 to one tablet) ON (can be increased to BD if needed, max 10mg/24 hours) Risperidone orodispersible tablet 0.5mg OD (can be increased to BD if needed)
Noisy respiratory Secretions		
	Standard Practice	Alternative
	Hyoscine Butylbromide (Buscopan®) 20mg SC PRN 6-8hrly Hyoscine Butylbromide (Buscopan®) 40 - 120mg/24hrs via a syringe driver.	Hyoscine Hydrobromide patch (Scopoderm®1.5mg patches) 1 patch every 72 hours. Patches can be cut into ¼ or ½ if dose reduction needed. Hyoscine Hydrobromide 300mcg tablets (Kwells®) SL 300 microgram TDS PRN.
Pain		
	Standard Practice	Alternative
Simple analgesia	Paracetamol 1g PO QDS max 4g/24hrs Use of NSAIDS for Covid-19 is currently not supported however if in the last days of life they may be considered.	Paracetamol suppositories 1g QDS PR can be used if unable to use via the oral route.

	However, if using consider Naproxen 500mg BD or Ibuprofen 400mg TDS	Diclofenac suppositories 50mg TDS (only to be used at End of Life)
Opioids		
Morphine - Use morphine first line if possible.	Oral Morphine solution (10mg/5ml) 2.5 to 5mg hourly PRN. If starting modified release Morphine consider a starting dose 10mg PO BD (reduce to 5mg BD if frail or concerned about dose e.g. due to known renal impairment). S/C morphine Morphine Sulphate injection 2.5mg to 5mg SC hourly PRN. Morphine 5mg to 20mg /24 if required in a syringe driver	Concentrated oral morphine (Oramorph concentrated solution 20mg/1ml®)can be used sublingually: - This as a last resort if nothing else available. - Some evidence of effect - Beware concerns as significant impact to over or under dose. - to aid identification the concentrated solution is RED in colour - 2mg = 0.1mls
Oxycodone - Oxycodone to be used if known morphine intolerance or known significant renal impairment. *Caution potency* PO Morphine: PO Oxycodone = 2:1	Oxycodone 1.25mg to 2.5mg PO hourly PRN (oral Oxycodone solution 5mg/5ml). If starting modified release consider oxycodone 5mg BD. S/C Oxycodone: Oxycodone injection 1.25 to 2.5mg SC hourly PRN Oxycodone 5mg to 20mg/24hrs if required in a syringe driver Start lower doses in opioid naïve, frail or elderly patients.	Concentrated Oxycodone (OxyNorm® Concentrate 10mg/ml oral solution) can be used sublingually: - This as a last resort if nothing else available. - Some evidence of effect - Beware concerns as significant impact to over or under dose. - to aid identification the concentrate solution is ORANGE in colour - 1mg = 0.1mls

e.g. Morphine 20mg PO = Oxycodone 10mg PO	If known or highly suspected renal failure please start: Oxycodone 5mg/24 hours and monitor.	
Transdermal Patches	Buprenorphine 5 microgram/hr patch equivalent to 15mg oral morphine/24 hours. Fentanyl 12 microgram /hr patch, equivalent to 30mg oral morphine/24 hours *Caution - If fever present there can be a surge in absorption, so use with caution.* *Patches also take time to reach a peak effect from 12-72 hours, limiting appropriate use.*	
Miscellaneous		
Abdominal colic	Hyoscine Butylbromide 20mg S/C PRN 6 hourly. Hyoscine Butylbromide: 60mg to120mg/24 hours if required in a syringe driver	Hyoscine hydrobromide 300mcg tablets (Kwells®) SL 300 microgram every TDS PRN. Hyoscine Hydrobromide (Scopoderm ® 1.5mg patch). Apply ONE patch every 72 hours. Patches can be cut into ¼ or ½ if dose reduction needed. Hyoscine hydrobromide may cause agitation/delirium – monitor for this and consider stopping should this occur.
Rapid acting fentanyl products such as Abstral or Effentora should only be used under advice of specialist palliative care team		

Nausea and Vomiting		
	Standard Practice	Alternative

Generalised nausea	Metoclopramide 10 mg PO/SC TDS PRN Haloperidol 1-1.5mg nocte PO or SC If risk of intolerances or parkinsonian side effects consider: Cyclizine 50 mg TDS PO or or Ondansetron 4-8 mg 4 hourly PRN max 16 mg in 24 hours.	Olanzapine orodispersible tablets 5mg, 2.5 to 5mg (1/2 to one tablet) ON (can be increased to BD if needed, max 10mg/24 hours) Prochlorperazine Buccal 3mg to 6mg every 12 hours Ondansetron orodispersible tablets 4mg 6-8 hourly PRN max 16mg/24hr
Refractory nausea	2nd : Levomepromazine 6.25 mg 4-6 hourly PO/SC If symptoms continue seek palliative care advice	Levomepromazine 6mg tablets (Levinan®) 3mg (1/2 tablet) 4-6 hourly PRN – please note can last 24 hours Olanzapine orodispersible tablets 5mg, 2.5 to 5mg (1/2 to one tablet) ON (can be increased to BD if needed, max 10mg/24 hours) Granisetron patch 3.1mg/24 hours, change every 7 days. **Please note – not ideal given time for effect & lack of PRN option, should be used only when all other options have failed**