Supportive and Palliative Care Temporary Guideline

End of Life Care Guidance when a Person is Imminently Dying from COVID-19 Lung Disease

Scottish Palliative Care Guidelines available online

www.scottishpalliativecareguidelines.scot.nhs.uk

Please contact your local palliative care team if you require advice. There may also be local guidelines available to which you should refer.

Background

The focus of this guideline is to reduce the suffering for those imminently dying from COVID-19 lung disease.

A proportion of patients dying of COVID-19 lung disease could have severe symptoms with rapid decline. In this situation it is important to deliver effective medications, at effective doses, from the outset. Early management of symptoms will be the most effective way to reduce suffering.

The clinical profile of COVID-19 lung disease driven dying is likely to include:

- High breathlessness / 'air hunger'
- High distress
- High delirium / agitation
- High fever
- Risk of cessation of life over a short number of hours.

This guideline should only be used when reversible causes for deterioration have been addressed and there is consensus that the patient is dying.

This guideline does not replace existing local and Scottish guidelines for symptom management (www.palliativecareguidelines.scot.nhs.uk) for all other clinical situations, and advice should be sought from your local palliative care team when needed.

This guidance has been developed by a rapid review process and independent reviews. It will be reviewed on a weekly basis as further evidence occurs.

Use of initial subcutaneous or intravenous bolus medications in severe symptoms alongside early commencement of syringe pumps is strongly recommended. This is because syringe pumps take at least 4 hours to reach full effect. If a syringe pump is not available then consider alternatives. Refer to: Alternatives to Regular Medication Normally Given via a Syringe Pump.

Route of delivery will depend on the individual clinical setting. Subcutaneous dosing is interchangeable with intravenous dosing where that route is available and more familiar.

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Medication[1]

Breathlessness			
Consider whether the patient is benefiting from any oxygen prescribed. If not, consider discontinuing non-beneficial oxygen and using medication and non-pharmacological measures for symptom control. Patients who are receiving medication via nebulisers may continue to do so in the context of COVID-19 lung disease. Currently corticosteroids are not recommended for managing the symptoms of dying of COVID-19 lung disease.			
Non-pharmacological measures to manage breathlessness should also be considered; these include positioning, relaxation techniques, wiping the face with cool wipes. **Fans must not be used in the context of COVID-19 infection as they increase aerosol spread of the virus.**			
Early commencement of syringe pump, if available, is strongly recommended.			
Morphine sulfate	Subcutaneous or slow intravenous injection	Start with 2 to 5mg as required; can be titrated to resolution of symptoms.	• Titration frequency: subcutaneous 10-15mins; intravenous 3-5mins. • Consider using the higher dose if the patient is very distressed with breathlessness. • Consider using lower doses in elderly patients. • In patients who are already receiving regular opioid, use 1/6 of total daily opioid dose for as required dose.
	Subcutaneous infusion	Start with 10 to 20mg over 24h.	

[1] † Indicates this use is off licence
QT Indicates this medication is associated with QT prolongation

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If the patient has known renal impairment (eGFR <30), consider using equivalent and equipotent doses of oxycodone, if immediately available, as required and alfentanil/oxycodone in an infusion. Refer to https://www.palliativecareguidelines.scot.nhs.uk/guidelines/pain/choosing-and-changing-opioids.aspx for conversions. If only one opioid is available, this should be used to relieve suffering in the setting of COVID-19 lung disease rapid dying.			
Midazolam	Subcutaneous or slow intravenous injection	Start with 2 to 5mg as required; can be titrated to resolution of symptoms.	• Consider using the higher dose if the patient is very distressed with breathlessness. • Consider using lower doses in elderly patients. • Maximum dose 100mg over 24h.
	Subcutaneous infusion	Start with 10 to 20mg over 24h.	

Cough			
Morphine sulfate	Oral	5mg every hour as required	• Consider using lower doses in elderly patients. • In patients who are already receiving regular opioid, use 1/6 of total daily opioid dose for as required dose.
	Subcutaneous injection	2mg every hour as required	
	Subcutaneous infusion	10 to 20mg over 24h	
Codeine linctus	Oral	60mg every 6 hours as required	
If the patient has known renal impairment (eGFR <30), consider using equivalent and equipotent doses of oxycodone, if immediately available, as required and alfentanil/oxycodone in an infusion. Refer to: https://www.palliativecareguidelines.scot.nhs.uk/guidelines/pain/choosing-and-changing-opioids.aspx for conversions. If only one opioid is available, this should be used to relieve suffering in the setting of COVID-19 lung disease rapid dying.			

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Respiratory Secretions			
Suction is not recommended for patients dying rapidly with COVID-19 lung disease. Focus should be on treatment of distress related to secretions, or medical treatment of secretions. Outwith this context, if suction is being used for symptomatic relief in a palliative care setting, an appropriate level of PPE is required. Refer to: Health Protection Scotland COVID-19 - guidance for infection prevention and control in healthcare settings https://www.hps.scot.nhs.uk/web-resources-container/covid-19-guidance-for-infection-prevention-and-control-in-healthcare-settings/			
Hyoscine Butylbromide	Subcutaneous injection	20mg every hour as required	• Alternative drugs and routes of administration are also available – Refer to: https://www.palliativecareguidelines.scot.nhs.uk/guidelines/symptom-control/considerations-during-coronavirus-pandemic-when-a-person-is-dying-from-causes-other-than-covid-19.aspx
	Subcutaneous infusion	Up to 180mg over 24h	
Glycopyrronium	Subcutaneous injection	200micrograms every hour as required	
	Subcutaneous infusion	1.2mg over 24h	
Hyoscine Hydrobromide	Subcutaneous injection	400micrograms every hour as required	
	Subcutaneous infusion	2.4mg over 24h	

Terminal delirium / Terminal agitation / Terminal restlessness			
A combination of midazolam and levomepromazine should be considered in terminal agitation/restlessness/delirium.			
Early commencement of syringe pump, if available, is strongly recommended.			
Midazolam	Subcutaneous or slow intravenous injection	Start with 2 to 5mg as required; can be	• Titration frequency: subcutaneous 10-15mins; intravenous 3-

		titrated to resolution of symptoms	5mins. • Maximum dose 100mg over 24h. • Better for agitation due to distress and anxiety. • Consider using lower doses in elderly patients. • High doses may be required in patients who have severe agitation.
	Subcutaneous infusion	Start with 10 to 20mg over 24h	
Levomepromazine	Subcutaneous injection	Start with 10 to 25mg every hour as required	• Doses over 100mg/day may be given under specialist advice. • Better for agitation due to delirium. • Consider using lower doses in elderly patients.
	Subcutaneous infusion	Start with 50mg over 24h (can be given as bd injections)	
Haloperidol Use where levomepromazine is not available.	Subcutaneous injection	1mg every 2 hours as required.	
	Subcutaneous infusion	Start with 5 to 10mg over 24h	
If the patient remains agitated, please contact your local palliative care team for further advice.			

Pyrexia			
Paracetamol	Oral, rectal or intravenous	1g every 4 to 6 hours; maximum 4g per day	• Use 500mg dose if: o Weight <50kg

			o Hepatic impairment o History of alcohol excess
Diclofenac	Oral or rectal	75mg to 150mg daily in divided doses	• Dilute in saline
	Subcutaneous or intramuscular injection	50mg every 8 hours as required	
	Subcutaneous infusion	150mg over 24h	
Ketorolac	Subcutaneous infusion	60mg over 24h	• Dilute in saline
	Subcutaneous injection	15mg every 8 hours as required	
Remember non-pharmacological measures such as reducing room temperature, removing excess bedding, and cooling forehead with tepid sponging (if PPE is available).			

Pain
Pain is not a prominent feature of COVID-19 lung disease. Paracetamol may be adequate analgesia in addition to the above medications for other symptoms. If this is not the case, refer to https://www.palliativecareguidelines.scot.nhs.uk/guidelines/pain.aspx for advice.