NHS
Oxfordshire
Clinical Commissioning Group

NHS
Oxford University Hospitals
NHS Foundation Trust

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 (should be followed if possible)	**Alternative** (only if standard practice not possible)
Opioid naïve (i.e. no previous opioids) and able to swallow	Morphine sulfate immediate-release 2.5 mg to 5 mg every 2 to 4 hours as required Or morphine sulfate modified-release 5 mg twice a day, increased as necessary (maximum 30 mg daily) In renal impairment: Oxycodone 1.25mg to 2.5mg PO hourly PRN (oral Oxycodone solution 5mg/5ml).	
Already taking regular opioids for other reasons (for example, pain relief)	Morphine sulfate immediate-release 5 mg to 10 mg every 2 to 4 hours as required or one twelfth of the 24-hour dose for pain, whichever is	

	greater	
Patients who are unable to swallow	Morphine sulfate 1 mg to 2 mg subcutaneously every 2 to 4 hours as required, increasing the dose as necessary If needed frequently (more than twice daily), a subcutaneous infusion via a syringe driver may be considered (if available), starting with morphine sulfate 10 mg over 24 hours, increasing stepwise to morphine sulfate 30 mg over 24 hours as required	**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 ***Caution strength - care when prescribing & dispensing***
If there is a strong anxiety component	Lorazepam 0.5 mg sublingually when required (maximum 4 mg daily) Reduce the dose to 0.25 mg to 0.5 mg in elderly or debilitated patients (maximum 2 mg in 24 hours) Midazolam 2.5mg to 5mg SC 1 to 2 hourly PRN SC	Buccal Midazolam (Buccolam®) 2.5mg prefilled oral syringes. 2.5mg 2 hourly PRN

	Midazolam 10 mg over 24 hours via the syringe driver, increasing stepwise to midazolam 60 mg over 24 hours as required	

Cough

Clinical Indication	Standard Practice	Alternative
Non-drug measures	Teaspoon of honey	
	Codeine linctus 30-60mg QDS PRN	Morphine Sulphate solution (10mg/5ml) 2.5mg to 5mg 4 hourly PRN if opioid naïve Increase to 5mg to 10mg 4 hourly if needed If the patient is already taking regular morphine increase the regular dose by a third

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 0.5 mg to 1 mg 4 times a day as required (maximum 4 mg in 24 hours) Reduce the dose to 0.25 mg to 0.5 mg in elderly or debilitated patients (maximum 2 mg in 24 hours) Oral tablets can be used sublingually (off-label use)	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 mg to 5 mg subcutaneously every 2 to 4 hours as required If needed frequently (more than twice daily), a subcutaneous infusion via a syringe driver may be considered (if available) starting with midazolam 10 mg over 24 hours Reduce dose to 5 mg over 24 hours if estimated glomerular filtration rate is less than 30 ml per minute	Buccal midazolam (Buccolam®) 2.5mg 2 hourly PRN
Delirium		
Clinical Indication	Standard Practice	Alternative
Patients who are able to swallow	Haloperidol 0.5 mg to 1 mg at night and every 2 hours when required. Increase dose in 0.5-mg to 1-mg increments as required (maximum 10 mg daily, or 5 mg daily in elderly patients)	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	Haloperidol 0.5 to 1mg SC at night and every 2 hours when required Or a continuous subcutaneous infusion of 2.5 mg to 10 mg over 24 hours Or Levomepromazine 12.5mg to 25mg SC hourly as required (use 6.25 mg to 12.5 mg in the elderly) (please note levomepromazine can last up to 24 hours) Or A continuous subcutaneous infusion of levomepromazine 50 mg to 200 mg over 24 hours , increased according to response (doses greater than 100 mg over 24 hours should be given under specialist supervision)	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. However, if using consider Naproxen 500mg BD or Ibuprofen 400mg TDS	Paracetamol suppositories 1g QDS PR can be used if unable to use via the oral route. 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 Sulfate 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	Oxycodone 1.25mg to 2.5mg PO hourly PRN (oral Oxycodone solution 5mg/5ml).	Concentrated Oxycodone (OxyNorm® Concentrate 10mg/ml oral solution) can be used sublingually:

intolerance or known significant renal impairment. *Caution potency* PO Morphine: PO Oxycodone = 2:1 e.g. Morphine 20mg PO = Oxycodone 10mg PO	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. If known or highly suspected renal failure please start: Oxycodone 5mg/24 hours and monitor.	- 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
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**

Patient Information Leaflets

Patient information leaflets to support conversations on off label use of end of life medicines can be found here**.**

Guaranteed Provision of Palliative Care Drugs Scheme

The document below includes a list of participating pharmacies and the list of palliative care drugs that these pharmacies are guaranteed to stock. It is recommended to call the pharmacy ahead to check if there is any issue, as well as to confirm pharmacy opening times as this may change due to the current pandemic. Please note that carers and healthcare professionals are not restricted to obtaining palliative care drugs only from the pharmacies taking part in this scheme. Prescriptions for palliative care drugs can be fulfilled by any other community pharmacy.

- Guaranteed Provision of Palliative Care Drugs in the Community