Clinical guidelines for the control of symptoms in the patient with COVID-19

In the acute phase, it is important that patients have their symptoms controlled alongside active medical treatment for COVID-19.

All patients should have anticipatory medications prescribed even if relatively stable in case of acute distressing deterioration: (NB Sedation and opioid use should **not** be withheld because of an inappropriate fear of causing respiratory depression)

- Midazolam 2.5mg-5mg SC PRN 1-2 hourly (for breathlessness or agitation)
- Haloperidol 0.5mg-1.5mg SC PRN (for nausea/vomiting/delirium)
- Morphine 2-3mg SC PRN 1 – 2 hourly or for eGFR <30 mL/min oxycodone 1-2mg SC PRN 1-2 hourly (for breathlessness/cough/pain) – please note if on regular opioids this dose will need to be adjusted and should be 1/6th of the regular background opioid dose – seek palliative care advice if needed or refer to trust anticipatory prescribing guidelines.
- Glycopyrronium 200microgram or Hyoscine Butylbromide 20mg (for respiratory secretions)

For patients with distressing breathlessness at rest please consider starting the following:

Opioid Naïve and unable to swallow	Opioid Naïve and able to swallow
Morphine sulphate 10mg + Midazolam 10mg subcut / 24hrs OR *if severe renal impairment* (eGFR <30 mL/min)*:* Oxycodone 5mg + Midazolam 10mg subcut / 24hrs ***Please note patients can still have additional PRN medications as required (doses as above for anticipatory medications)***	Morphine modified release 10mg BD (or oxycodone modified release 5mg BD if eGFR <30) ***Plus*** regular lorazepam 500 microgram BD and PRN lorazepam 500 microgram (4 hourly) ***Plus*** Morphine sulphate immediate release solution 5mg PO PRN 1-2 hourly (or eGFR <30 mL/min use OxyNorm 2.5mg PO PRN 1-2 hourly) and PRN lorazepam 500 microgram
Doses may need to be increased if severe symptoms or if previously on regular opioids/benzodiazepines; please ring palliative care team for advice	

Should a patient rapidly deteriorate despite active management then please follow the Trust end of life care guidance

If we get to a situation where syringe drivers are regularly in short supply this guidance will be updated and re circulated. In the meantime should this happen please contact your palliative care teams for advice and make sure the PRN SC or PO medications are prescribed as described above.

For further advice please contact palliative care team directly:

SGH: 03033 302949 or bleep 2228/2063

North Lincolnshire Community: 03033 306937

DPOW: 03033 303798/317 or bleep 270/087

North East Lincolnshire Community 01472 250623

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In addition to this for patients with COVID-19, please ensure the following symptoms are considered and PRN/regular medication prescribed as needed alongside the anticipatory medications:

Symptom	Clinical indication	Recommendation
Mild breathlessness (at rest or minimal exertion) *(Please note if there is also an element of anxiety then you can use benzodiazepines alongside opioids as described below)*	Opioid naïve (i.e. no previous opioids) and able to swallow	• Morphine sulphate immediate release solution 2.5 to 5mg PO PRN 1-2 hourly (if eGFR <30 mL/min use OxyNorm 1-2mg PO PRN 1-2 hourly) • If effective and needing two or more doses daily, consider starting Morphine modified release 5mg – 10mg PO BD (if eGFR <30 mL/min oxycodone modified release 5mg BD) • Continue with PRN doses and if still needing two or more doses over 24 hours consider titrating modified release doses further, adding in benzodiazepines if not already using them and seeking palliative care team advice
	Patients who are on regular opioids for pain relief	• Immediate release oral morphine sulphate 5 to 10mg PO PRN 1–2 hourly or one sixth of the 24 hour background dose for pain (whichever is greater) • If eGFR <30 mL/min or on regular Oxycodone modified release use OxyNorm 2.5mg – 5mg PO PRN 1-2 hourly or one sixth of the 24-hour background dose for pain (whichever is greater) • Seek palliative care team advice if needed
	Patients who are unable to swallow	• Morphine 2-3mg SC PRN 1–2 hourly • for eGFR <30 mL/min oxycodone 1-2mg SC PRN 1–2 hourly • if effective and needing two or more doses daily consider starting syringe driver with Morphine 10mg over 24 hours (or if eGFR <30 Oxycodone 5mg over 24 hours) • Continue PRN doses prescribed and if still needing two or more doses over 24 hours consider titrating syringe driver dose further, adding in benzodiazepines if not already using them and seeking palliative care team advice
Anxiety	Patients who are able to swallow	• Lorazepam 500 microgram sublingual PRN (4 hourly) • If needing two or more doses daily consider adding Lorazepam 0.5mg – 1mg BD
	Patients who are unable to swallow	• Midazolam 2.5mg – 5mg subcut PRN • If needing two or more doses daily consider starting syringe driver (starting dose Midazolam 10mg /24hr - reduce to 5mg if eGFR<30)
Cough	Opioid naïve	• Simple linctus-5mls QDS • If ineffective Morphine sulphate immediate release solution 2.5 to 5mg PO PRN 1-2 hourly (if eGFR <30 use OxyNorm 1-2mg PO PRN 1-2 hourly)
Fever		• Regular antipyretics, such as paracetamol PO/IV/PR • If paracetamol not effective and pyrexia causing ongoing distress seek advice from palliative care team