# COVID-19 Palliative Care Guidance for Community Professionals

**This document has book marked links & external links.**

**Click on the blue text to jump to the section or external resource you are looking for.**

**Existing symptom control guidance for patients who do NOT have Covid-19 infection is available here**

## OVERGATE HOSPICE INPATIENT UNIT

Overgate Hospice Inpatient Unit remains open for specialist palliative care and end of life care for patients with a life-limiting illness whose palliative needs cannot be met anywhere else.

**We now have some supplies of PPE. *Providing a patient does not need aerosol-generating procedures*, from 9th April 2020 will be able to accept referrals for patients who have suspected or confirmed Covid-19 infection and if they meet our other referral criteria, while also keeping our other patients safe.**

Our **visiting arrangements** are under constant review – please see our website

## PALLIATIVE CARE GUIDANCE for COMMUNITY PROFESSIONALS during the COVID-19 PANDEMIC

The demand in community for palliative care support will increase, and we have produced this guidance document, based on ***NICE COVID-19 rapid guideline: [NG163] managing symptoms (including at the end of life) in the community,*** released 4.4.2020 (Click here to read the full guidance) and on guidance from the Association for Palliative Medicine (click **here** to read full guidance)

The key steps for effective palliative care are:

1. **Identify**
2. **Assess**
3. **Plan**
4. **Care after death**

# COVID-19 Palliative Care Guidance for Community Professionals

## Identify

**Identify those most at risk from Covid-19**
**SHIELDING GUIDANCE** is here

**Identify those unlikely to benefit from escalation of treatment**
(Will my patient benefit from hospital admission / NIV / ITU /intubation?)

- **FRAILTY SCORE** is here
- **ESCALATION PLANNING** guidance is here

## Assess

**STAYING SAFE IN PRIMARY CARE – Remote assessments**

BMJ guidance on Covid-19: a remote assessment in primary care

Visual summary for remote consultations

### Calderdale Community Specialist Palliative Care Team

- Team members are working remotely, and prioritising patients with current and urgent need. Please continue to refer to the via communityspecialist.palliativecare@nhs.net (secure email preferred) or by phone **01422 310874**.
- The team still supports patients and families via phone assessment, escalating concerns to GP teams as needed, and is available to give advice to professionals. (Each GP Team and CHFT Community service Hubs have CNS mobile contact details listed for direct / urgent access),
- Working hours are **Mon-Fri 9am to 5pm** - Outside those hours, please call Overgate Hospice for advice on **01422 379151**

### Out-of-Hours Palliative Care service

- The service still works in the same way (7-day service 8pm to 5am alongside other OOH DN teams and now operates from the central Halifax Hub.
- All calls to the OOH Nursing services are triaged **07917106263.**

## Plan

### Planning care and treating symptoms in patients with Covid-19 infection

**Advance Care Planning**

- DNA CPR
- Escalation of care – who amongst your patients would **not** benefit from admission to hospital, NIV, intubation, ITU?

**Common Symptoms in those dying from Covid-19 infection, and how to treat**

**If medications are in short supply**
Alternatives to first line symptom control medications

**How to prescribe if you cannot access a syringe driver**

**Lay carers giving injections**
if district nurse can't attend promptly

# IDENTIFY

## SHIELDING

**Link to full gov.uk guidance is here**

People falling into this extremely vulnerable group include:

1. Solid organ transplant recipients.
2. People with specific cancers:
   - people with cancer who are undergoing active chemotherapy
   - people with lung cancer who are undergoing radical radiotherapy
   - people with cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment
   - people having immunotherapy or other continuing antibody treatments for cancer
   - people having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors
   - people who have had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs
3. People with severe respiratory conditions including all cystic fibrosis, severe asthma and severe COPD.
4. People with rare diseases and inborn errors of metabolism that significantly increase the risk of infections (such as SCID, homozygous sickle cell).
5. People on immunosuppression therapies sufficient to significantly increase risk of infection.
6. Women who are pregnant with significant heart disease, congenital or acquired.

Shielding is for your personal protection. It is your choice to decide whether to follow the measures we advise. Individuals who have been given a prognosis of less than 6 months to live, and some others in special circumstances, could decide not to undertake shielding. This will be a deeply personal decision. We advise calling your GP or specialist to discuss this.

## ASSESSING FRAILTY

**Link to detail regarding this scale is here**

### Clinical Frailty Scale*

**1 Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

**2 Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

**3 Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

**4 Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

**5 Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

**6 Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

**7 Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

**8 Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

**9. Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently fra**

**Scoring frailty in people with dementia**

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.



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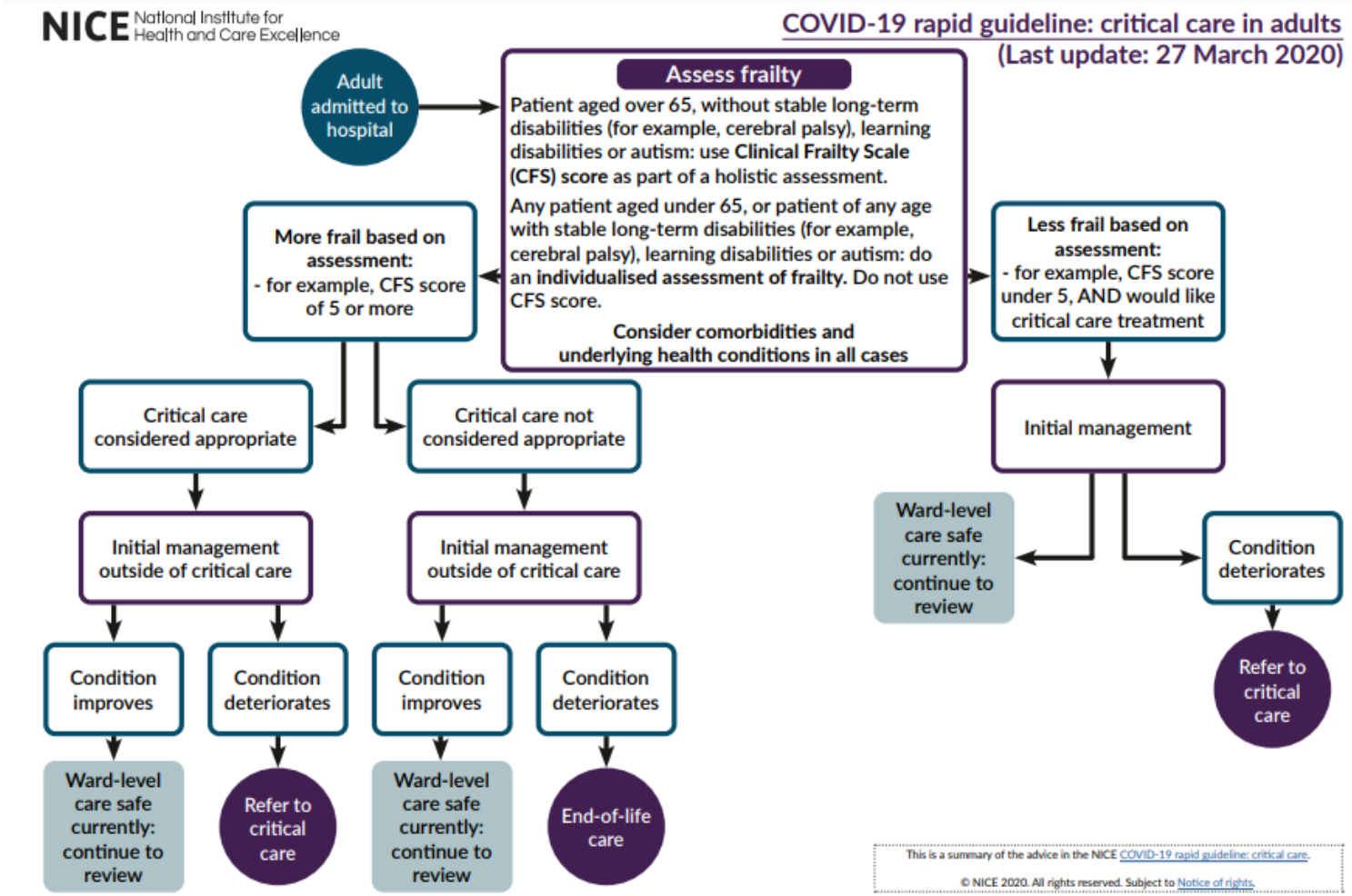
# IDENTIFY

## ESCALATION PLANNING

**Link to the full NICE guidance on escalation planning during the Covid-19 pandemic is here**



# PLAN – Advance Care Planning

## Who makes decisions about DNA CPR and escalation plans?

Where the **professional believes a treatment has a good chance of success,** then it's the **patient's decision** about whether they would want the treatment.

**Ask the patient what they want.**

**KEY QUESTIONS to ASK YOURSELF as a PROFESSIONAL:**

- Would CPR revive this patient?
- Would this patient survive ITU, and be successfully weaned from a ventilator?
- Would this patient's prognosis be improved by being admitted to hospital?

If the answer to these questions is "**yes**" then **ask** the person whether they would want the treatments.

Then document that plan on the electronic record (EPaCCS if you have access) and on paper notes in the house (OOH handover form).

Where the **professional knows a treatment would not help** someone, it is the professional's decision.

In this situation, **the professional must "tell" (not ask)** – ie explain that the treatment won't be offered.

**KEY QUESTIONS to ASK YOURSELF as a PROFESSIONAL:**

- Would CPR revive this patient?
- Would this patient survive ITU, and be successfully weaned from a ventilator?
- Would this patient's prognosis be improved by being admitted to hospital?

If the answer to these questions is "**no**" then **don't ask** what the person wants.....**explain** that these treatments would not work.

Then document that plan on the electronic record (EPaCCS if you have access) and on paper notes in the house (OOH handover form).

## DNA CPR & Advance Care Planning (ACP) Decisions & Discussions

**Decisions must be made on an individual patient basis.**

Useful video about CPR here

Involve the patient, and their family (with patient consent) wherever possible.

***Decisions*** **about whether or not to offer CPR should be based on existing guidance from the GMC and the Resuscitation Council**

***Decisions about escalation*** **should be based on NICE guidance**

Tips for talking to patients about advance care planning, DNA CPR etc during the Covid-19 pandemic are available from VITALtalk , including suggested responses to angry or distressed comments from patients and family members.

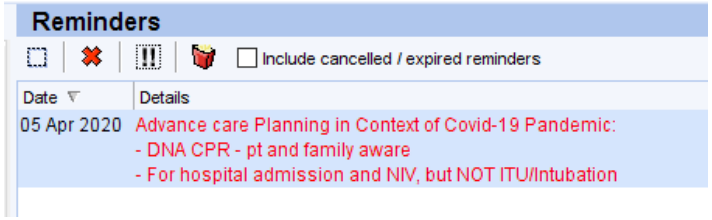
**https://www.vitaltalk.org/guides/covid-19-communication-skills/**

VITALtalk

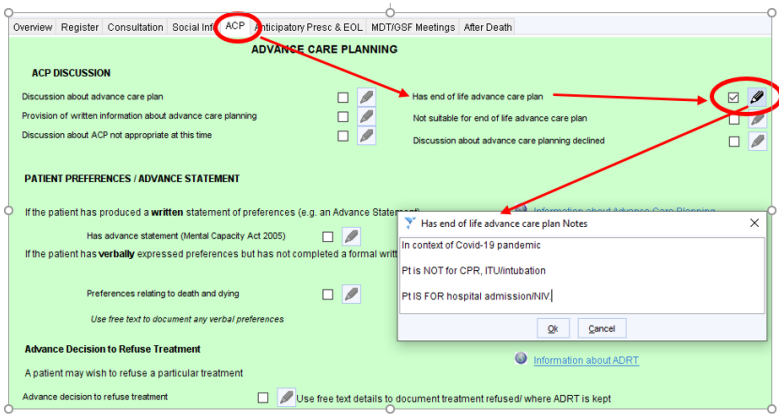
## Documenting decisions

Important places to document outcomes of ACP are:

1. **Out of Hours Palliative Care Handover Form** in the patient's house
2. **Font page of SystmOne/ EMIS record** (S1 example below – high priority reminder on front page)




3. **EPaCCS** (S1 example below)



# Common Symptoms of Covid-19 & treatment at the end of life

## Shortness of Breath

Jump to management of SOB

## Cough

Jump to management of cough

## Anxiety, Agitation, Delirium

Jump to management of anxiety, agitation, delirium

## Sputum / secretions

Jump to management of sputum/secretions

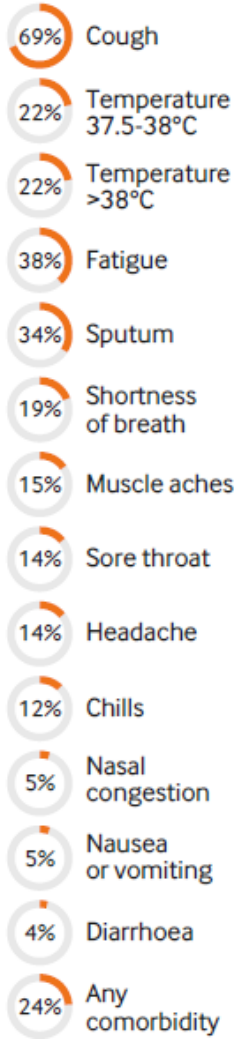
## Fever

Jump to management of fever

## Pain

Jump to management of pain

Frequency of symptoms in Wuhan



# Shortness of breath – management at end of life in Covid-19 infection

Link to NICE guidance https://www.nice.org.uk/guidance/ng163/chapter/6-Managing-breathlessness

Breathlessness is a pronounced symptom in some patients dying from Covid-19 infection

****Deterioration from Covid-19 infection can be very rapid if there is a cytokine storm****
**If patient needs medication, give PRN loading doses, even if starting a syringe driver.**

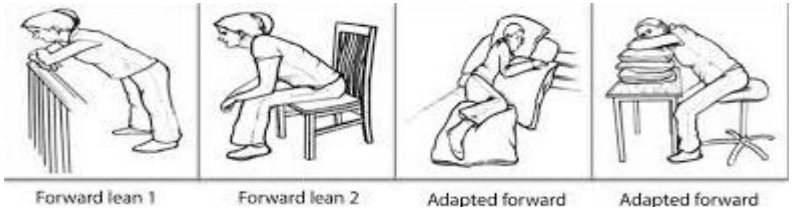
If there is no supply of the recommended medication, please see a list of alternatives here.

## Non-pharmacological Measures

*Cooling*
- Keep room **cool** (open window)
- **Fans should not be used** if Covid-19 is suspected or confirmed

*Relaxation and breathing exercises*
- pursed lips, long outbreath

*Position*
- **Sit up** in bed / regularly **change position**
- **Avoid lying flat on back** – as this results in ineffective cough/poor ventilation




## Pharmacological Measures

*Consider treating pulmonary oedema if it is adding to symptoms*

*Consider low flow oxygen therapy if $O_2$ saturations reduced*
- If history of COPD, or type 2 Respiratory failure, aim for saturations of 88-92%
- If no COPD, aim for sats 94-96%
  (ref – section 4.4)
- Do not use high flow nasal oxygen due lack of efficacy & risk of aerosol spread

### *Opioids 1st line*

***Is breathlessness severe?***

**NO**

**If opioid naïve / eGFR>40**
- **PRN oramorph 2.5-5mg**
- **Regular Morphine sulphate MR 5mg BD**
  (max 30mg/24 hrs)

**If already on opioids / eGFR>40**
- PRN oramorph 5-10mg PRN

**Prescribe anticipatory SC opioid & midazolam PRN if the patient might die**

**For eGFR 15-40 use oxycodone**
**For eGFR<15 seek specialist advice.**
**See opioid conversion guidance**

**YES**

**If opioid naïve / eGFR>40**
- **morphine sulphate injection**
  1-2mg S/C PRN

- S/C Syringe driver
  **morphine sulphate**
  10mg/24 hrs (max 30mg/24hrs)

### *Benzodiazepines 2nd line*

**Breathlessness at the end of life**
- **PRN lorazepam** 0.5-1mg S/L (max 4mg/24hrs)
- **PRN midazolam** 2.5-5mg SC
- **Syringe driver midazolam** 10mg/24hrs (max 80mg/24hrs)

# Anxiety, delirium and agitation – management at end of life in Covid-19 infection

Link to NICE guidance https://www.nice.org.uk/guidance/ng163/chapter/7-Managing-anxiety-delirium-and-agitation

Delirium and agitation can be pronounced symptoms in some patients dying from Covid-19 infection, especially the elderly

****Deterioration from Covid-19 infection can be very rapid if there is a "cytokine storm"****
**If patient needs medication, give PRN loading doses, even if starting a syringe driver.**

If there is no supply of the recommended medication, please see a list of alternatives here.

## Non-Pharmacological Measures

**DELIRIUM**

- This may be due to Covid-19 infection itself, but **reverse any reversible causes** (e.g. Is the patient constipated, in urinary retention, in pain, anxious?)
- Adequate lighting
- Calm atmosphere…
  **explain** what's happening to carers
- Offer orientation to person, place, time
- May need to treat anxiety – see opposite

## Medication

### ANXIETY & AGITATION

| Patient not dying / can swallow | Patient dying/can't swallow |
|---|---|
| **PRN**<br>**Lorazepam 0.5-1mg**<br>Oral or sublingually (S/L)<br>Max 4mg / 24 hrs<br>Consider reducing dose in elderly<br>**Prescribe anticipatory SC midazolam & levomepromazine if the patient might die** | **PRN**<br>1st line **Midazolam** 2.5-5mg SC PRN<br>2nd line **Levomepromazine** 25-50mg SC PRN<br>3rd line **Phenobarbital** 100-200mg IM hourly PRN<br>**Background Syringe Driver**<br>-Midazolam 10mg/24hrs (max 80mg/24hrs) **or**<br>-Levomepromazine 25mg/24hrs (max 200mg) **or**<br>-Phenobarbital 600mg/24hrs (seek specialist advice) |

### DELIRIUM

| Patient not dying / can swallow | Patient dying/can't swallow |
|---|---|
| **Stat then 2 hourly PRN**<br>**Haloperidol 0.5-1mg nocte oral**<br>**Higher doses if delirium severe (1.5-3mg)**<br>Titrate up to **max 10mg/day** (5mg if elderly)<br>Consider adding benzodiazepine if patient remains agitated/anxious (see above)<br>**Prescribe anticipatory SC levomepromazine if the patient might die** | **Stat then hourly PRN**<br>**1st line Levomepromazine 12.5 -25mg SC**<br>Max PRN dose 50mg SC<br>**2nd line Phenobarbital 100-200mg IM PRN**<br>**Syringe driver**<br>**Levomepromazine 50-200mg/24 hours** or<br>**Phenobarbital 600mg/24hrs** (seek specialist advice) |

# Cough – management at end of life in Covid-19 infection

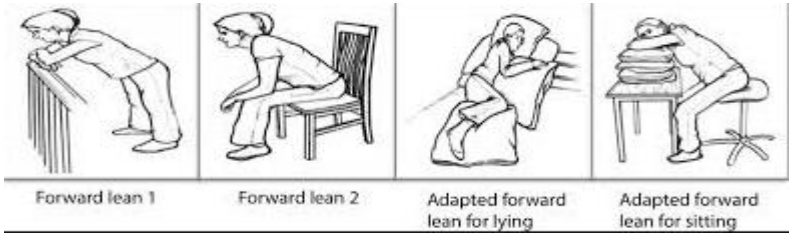
Link to NICE guidance: https://www.nice.org.uk/guidance/ng163/chapter/4-Managing-cough

## Non-pharmacological measures

Reduce viral spreading


Avoid lying on back

Try to lie on side / sit up / changing position etc




For mild cough, in adults, try taking simple remedies e.g. a teaspoon of honey (e.g. dissolved in warm water)

## Pharmacological treatment

**First line**, only if cough is distressing:

**Codeine linctus or codeine phosphate tablets**

- 15-30mg 4 hrly PRN (max 240mg/24hrs)
- Can increase to 30-60mg PRN (max 240mg/24hrs)

**Second line**, only if cough distressing

**For eGFR 15-40 use oxycodone**
**For eGFR<15 seek specialist advice**
**See opioid conversion guidance**

ORAL

**Oral morphine solution 2.5-5mg 4 hrly PRN**

**Increase to 5-10mg 4hrly if required**

S/C

**Morphine sulphate injection SC 1.25-2.5mg 4hrly PRN**

**Increase to 2.5-5mg 4hrly if required.**

Using SC medication should be reserved for those who are dying, who cannot swallow, or whose symptoms are not relieved by codeine (above)

**If patient already taking /background morphine, increase doses by $^{1}/_{3}$**

# Sputum & Secretions – management at end of life in Covid-19 infection

(no specific NICE guidance in Covid-19)

## Keep safe!

If your patient is coughing or sneezing**, you need to wear eye protection as well as your mask,** gloves and apron.

**Consider asking the patient to wear a surgical mask** if you are supporting them with breathing exercises (huffing/ breath stacking etc.)

If your patient needs **suction or a cough assist machine, this can create an aerosol, so you must use an FFP3 mask instead of a fluid resistant surgical mask, and you must have been fit tested for that brand.**

## Non-Pharmacological Measures

**For all, to improve the effectiveness of the cough**

- Partly/fully upright posture
- Frequent change in posture
- Try getting the patient to do breath-stacking / huffing

For **thick sputum**

- Keep the room humidified – e.g. with a bowl of warm water

## Medication for sputum management

Avoid steroids unless the patient is dying

### Excessively Thick Sputum

- **Saline 0.9% 5ml nebule QDS & PRN**
  NB a nebuliser is not deemed an aerosol generating procedure for the purposes of PPE
- **Carbocisteine 750mg BD – TDS**

### Excess Thin Sputum

- **Amitriptyline 10-25mg oral nocte**
- **Hyoscine hydrobromide patch 1mg**
  (change every 72 hours)

## Excess secretions in the dying patient

- Stat dose **and** syringe driver at the earliest sign of secretions
- **Hyoscine butylbromide 20mg SC stat & PRN**
- **Syringe driver: Hyoscine butylbromide 60mg/24hrs**
  (seek advice if needing doses of >120mg/24hrs)

# **Fever** – management at end of life in Covid-19 infection

Link to NICE guidance: https://www.nice.org.uk/guidance/ng163/chapter/5-Managing-fever

## Non-Pharmacological Measures

If a patient develops Covid-19 infection, fever most commonly **starts 5 days after exposure**

**Avoid fans**

**Open a window** if possible

Wear clothing made of **natural fibres** if possible

**Keep well hydrated**
(maintain oral fluid intake ,
but not more than 2 litres/day)

Antipyretics are not recommended for fever alone**, but in dying patients, or patients who are suffering as a result of their fever, then antipyretics may be indicated for comfort.**

## Pharmacological Measures

Avoid NSAIDS unless the patient is in the dying phase

### For patients who can take **oral medication**

**For patients weighing <50kg**
**Paracetamol 500mg QDS**
**PRN or regular**(2g/day max)

**For patients weighing ≥50kg**
**Paracetamol 1g QDS**
**PRN or regular** (4g/day max)

Avoid giving **paracetamol PR** unless antipyretic is **necessary and there is no other option** as there are reports of PR viral shedding.

### For patients who are in **dying phase and cannot manage oral** medication

Consider **ketorolac**
**15-30mg SC PRN**
Max dose = 90mg/ 24hrs

NB in addition to the usual side effects of NSAIDS, there are **unproven** concerns that NSAIDS may worsen outcomes in Covid-19 infection. However, until the situation is clarified, it is recommended that NSAIDS should only be used where any harm will not affect overall outcomes for the patient.

The MHRA alert is here

# **Pain** – management at end of life in Covid-19 infection

(no specific NICE guidance in Covid-19)

**Patients with Covid-19 infection may have pain either from pre-existing conditions or may have pain from excessive coughing or immobility.**

## Mild Pain

- **For patients weighing <50kg**
  **Paracetamol 500mg QDS PRN or regular** (2g/day max)
- **For patients weighing ≥50kg**
  **Paracetamol 1g QDS PRN or regular** (4g/day max)

**Avoid NSAIDS unless the patient is dying**

## Moderate pain

If paracetamol is not effective, pain relief may be achieved more effectively and quickly by using low dose strong opioids than by using weak opioids. However, codeine is easier to supply. Either of the following would be appropriate:

- **Codeine phosphate 30-60mg QDS PRN or**
- **Oral morphine solution 2-4mg QDS PRN oral**

**Prescribe anticipatory SC morphine sulphate or alternative opioid if the patient might die**

## Severe pain, and pain in the dying phase

### For patients who HAVE NOT taken strong opioids before

| PATIENT **CAN** SWALLOW | PATIENT **CANNOT** SWALLOW |
|---|---|
| **Morphine sulphate solution 2-5mg oral QDS PRN**<br>If effective, convert to BD modified release morphine preparation, and continue with PRN doses. | **Morphine sulphate injection 1-2mg SC QDS PRN**<br>If effective, convert to 24 hrly morphine sulphate requirement to a syringe driver, and continue with PRN doses. |

### For patients who ARE ALREADY taking strong opioids

- if adjusting the dose of opioid, take prn doses into account
- check that the opioid is effective before increasing the dose
- increments should not exceed 33-50% every 24 hours
- titration of the dose of opioid should stop when either the pain is relieved or unacceptable side effects occur
- if pain control achieved on IR consider conversion to MR opioid (same 24-hour total dose)
- seek specialist advice if analgesia titrated 3 times without achieving reasonable pain control **OR** 3 or more prn doses per day **OR** total daily dose of oral morphine over 120mg/day unacceptable side effects

**For eGFR 15-40 use oxycodone instead of morphine sulphate. For eGFR<15 seek specialist advice. See opioid conversion guidance**

# Alternatives to first line medications if in short supply

Seek specialist advice if unsure

## Breathlessness

**Alternatives to Oral morphine solution** – sevredol (immediate release morphine tablets): oxycodone immediate release (capsules/liquid)
**Alternatives to morphine sulphate injection** – oxycodone injection PRN or in syringe driver, alfentanil in syringe driver, buprenorphine patch or fentanyl patch.

**See opioid conversion guidance**

## Cough

**Alternatives to Oral morphine solution** – sevredol (immediate release morphine tablets): oxycodone immediate release (capsules/liquid)
**Alternatives to morphine sulphate injection** – oxycodone injection PRN or in syringe driver, alfentanil in syringe driver, buprenorphine patch or fentanyl patch.

**See opioid conversion guidance**

## Anxiety, Agitation, Delirium

**Alternatives to midazolam**

**Mild symptoms**

Lorazepam 0.5-1mg Sublingual (max 4mg/day) **PRN or regular**

**Severe symptoms**

Levomepromazine SC 25-50mg SC **PRN**
Levomepromazine25-200mg/24 hrs in a **Syringe driver**
Phenobarbital 100-200mg IM **PRN**
Phenobarbital starting with 600mg/24hrs in a **Syringe driver**

## Sputum & Secretions

**Alternatives to hyoscine butylbromide** for oropharyngeal secretions at the end of life are:

- **Hyoscine hydrobromide**
  400micrograms SC PRN
  1200micrograms/24hrs in a syringe driver
- **Glycopyrronium Bromide**
  200micrograms SC PRN
  600-1200micrograms/24hrs in a syringe driver

## Fever

While antipyretics are not necessary for fever alone, if paracetamol is not available, and the patient is not expected to recover, injections of ketorolac 15-30mg SC are acceptable. (90mg/24hrs max)

AVOID NSAIDS if patient is expected to recover.

## Pain

**Alternatives to Oral morphine solution** – sevredol (immediate release morphine tablets): oxycodone immediate release (capsules/liquid)
**Alternatives to morphine sulphate injection** – oxycodone injection PRN or in syringe driver, alfentanil in syringe driver, buprenorphine patch or fentanyl patch.

**See opioid conversion guidance**

# What / how to prescribe if a syringe driver is not available

**For eGFR 15-40 use oxycodone instead of morphine sulphate. For eGFR<15 seek specialist advice. See opioid conversion**

## Breathlessness

**IF ABLE TO SWALLOW**

- **Morphine IR** (oramorph or sevredol tablets) PO 2.5-5mg (PRN 1-2 hrly)
- **Lorazepam** 0.5-1mg SL (PRN 4 hourly) Max 4mg/24hours

**IF NEEDING REGULARLY**

Regular 4 hourly administration with PRN doses in between as needed (or escalate to SC medication)

Consider **Fentanyl** patch 12-25mcg/hr ONLY IF PROGNOSIS FELT TO BE DAYS RATHER THAN HOURS

**IF UNABLE TO SWALLOW**

- **Morphine** SC 2.5-5mg (PRN 1-2 hourly) **THEN ADD**
- **Midazolam** SC 2.5-5mg (PRN 1-2 hourly)

**IF NEEDING REGULARLY**

Regular 4 hourly administration with PRN doses in between as needed.

Consider increasing dose of Morphine if not effective.

Consider **Fentanyl** patch 12-25mcg/hr ONLY IF PROGNOSIS FELT TO BE DAYS RATHER THAN HOURS

## Respiratory secretions at end of life

**Hyoscine hydrobromide (scopaderm) patch** 1mg/72 hours, max 2mg **THEN ADD**

**Hyoscine butylbromide** 20mg SC (PRN or regularly 4 hourly) max 120mg/ 24hrs **THEN ADD**

**Atropine 1% ophthalmic solution used ORALLY**, up to 4 drops QDS. Likely only to be effective if thin watery solutions

## Fever

**IF ABLE TO SWALLOW:** **paracetamol** 1g QDS (500mg QDS if weighs <50kg)

**IF UNABLE TO SWALLOW: ketorolac** 15-30mg SC PRN (max 90mg/24 hrs)

## Agitation / Delirium

**IF ABLE TO SWALLOW**

**Lorazepam** 0.5-1mg SL (PRN 4 hourly) Max 4mg/24hours **THEN ADD**

**Levomepromazine** PO 12.5-25mg (PRN 4 hourly) Can be crushed

**IF NEEDING REGULARLY**

Regular 4 hourly administration Lorazepam with PRN doses in between **PLUS**

**Levomepromazine** PO 25mg nocte (up to 50mg QDS if dying)

**IF UNABLE TO SWALLOW**

**Midazolam** SC 2.5-5mg (PRN 1-2 hourly) **THEN ADD**

**Levomepromazine** SC 25mg (PRN 4 hourly)

**IF NEEDING REGULARLY**

Regular 4 hourly administration of **Midazolam** with PRN doses in between.

Consider increasing dose of Midazolam to 10mg if needed.

**PLUS Levomepromazine** SC 25mg nocte (and up to 50mg QDS if dying)

## Pain

**IF ABLE TO SWALLOW**

**Morphine IR** (oramorph or sevredol tablets) PO 2.5-5mg (PRN 1-2 hourly)

**May need larger dose if on regular background opioids** (continue while able)

**IF NEEDING REGULARLY**

Regular 4 hourly administration with PRN doses in between.

Consider **Fentanyl patch** ONLY IF PROGNOSIS FELT TO BE DAYS RATHER THAN HOURS

**IF UNABLE TO SWALLOW**

**Morphine sulphateSC** 2.5-5mg (PRN 1-2 hourly)

**May need larger dose if on regular background opioids**

**IF NEEDING REGULARLY**

Regular 4 hourly administration with PRN doses in between

Consider increasing dose of Morphine if not effective.

Consider **Fentanyl patch** ONLY IF PROGNOSIS FELT TO BE DAYS RATHER THAN HOURS

# Opioid conversion guidance

**For eGFR >40** – use morphine sulphate first line regular and PRN

**For eGFR 15-40** – use oxycodone regular and PRN

**For eGFR <15 – use alfentanil in SD or a patch / oxycodone PRN**

| Morphine sulphate Oral | | | Oxycodone Oral | | | Morphine sulphate Subcutaneous | | Oxycodone Subcutaneous | | Fentanyl Transdermal | Alfentanil Subcutaneous |
|---|---|---|---|---|---|---|---|---|---|---|---|
| PRN dose (mg) | 12hr MR dose (mg) | 24hr total dose (mg) | PRN dose (mg) | 12hr MR dose (mg) | 24hr total dose (mg) | PRN dose (mg) | 24hr total dose (mg) | PRN dose (mg) | 24hr total dose (mg) | Patch Strength (microgram/hr) | 24hr total dose (mg) |
| 2.5 | 10 | 20 | 1 - 1.5 | 5 | 10 | 1.5 | 10 | 1 | 5 | - | 0.5 |
| 5 | 15 (MST) | 30 | 2.5 | 10 | 20 | 2.5 | 15 | 1 - 1.5 | 7.5 | - | 1 |
| 10 | 30 | 60 | 5 | 15 | 30 | 5 | 30 | 2.5 | 15 | 12 mcg* | 2 |
| 15 | 45 | 90 | 7.5 - 10 | 25 | 50 | 7.5 | 45 | 2.5 - 5 | 25 | 25 mcg | 3 |
| 20 | 60 | 120 | 10 | 30 | 60 | 10 | 60 | 5 | 30 | 37 mcg* | 4 |
| 30 | 90 | 180 | 15 | 45 | 90 | 15 | 90 | 7.5 | 45 | 50 mcg | 6 |
| 40 | 120 | 240 | 20 | 60 | 120 | 20 | 120 | 10 | 60 | 75 mcg* | 8 |
| 50 | 150 | 300 | 25 | 75 | 150 | 25 | 150 | 12.5 | 75 | 75 mcg* | 10 |
| 60 | 180 | 360 | 30 | 90 | 180 | 30 | 180 | 15 | 90 | 100 mcg | 12 |
| 70 | 210 | 420 | 35 | 100 | 200 | 35 | 210 | 17.5 | 100 | 125 mcg* | 14 |
| 80 | 240 | 480 | 40 | 120 | 240 | 40 | 240 | 20 | 120 | 125 mcg* | 16 |
| 90 | 270 | 540 | 45 | 135 | 270 | 45 | 270 | 22.5 | 135 | 150 mcg* | 18 |
| 100 | 300 | 600 | 50 | 150 | 300 | 50 | 300 | 25 | 150 | 150 mcg* | 20 |
| 110 | 330 | 660 | 55 | 160 | 320 | 55 | 330 | 27.5 | 160 | 175 mcg | 22 |
| 120 | 360 | 720 | 60 | 180 | 360 | 60 | 360 | 30 | 180 | 200 mcg | 24 |

*Actual conversion from oral morphine is 45mg oral morphine per day = 12 microgram/hour fentanyl patch, hence those transdermal fentanyl doses with an asterisk are not direct conversions but should be used as an approximate guide. All conversions are approximate and conversions at higher doses should be discussed with a Palliative Medicine Consultant. Doses for opioid naïve patients should start low and be titrated against response

Adapted with thanks from the CHFT palliative care guidelines.

# Care after Death - following Covid-19 Infection

Link to guidance: https://www.effs.eu/files/effs/content/AT%20Joint-Statement-on-Coronavirus-Act-2020-002.pdf

## VERIFICATION OF EXPECTED DEATH (VOED)

Nurses may verify the death of a patient who has died of Covid-19 infection, providing other criteria are met for usual nurse verification of expected death.
At present, the policy for community nurses working in Calderdale allow them to undertake VOED if the patient has been seen by the GP in the last 14 days.

## CERTIFICATION (Medical certificate of Cause of Death)

**Email copy of MCCD to register.office@calderdale.gov.uk**

**If the doctor who attended the person before death is unavailable, another doctor can sign the MCCD for all deaths which are natural, including Covid-19.**

- This will only be when the certifying doctor is able to access the deceased's notes and the information supports a natural death.
- There is still a requirement for the deceased to be seen after death or within 28 days prior to death by a doctor.
- The same MCCD form will be used and amended as necessary.

**There is no need for the certifying doctor to have attended the deceased during their last illness.**

**The time period for the deceased to have been seen by a doctor, prior to death, is extended from 14 to 28 days.**

- There is still a requirement for the body to be seen after death if they were not seen by a doctor up to 28 days prior to death.
- Currently, the **certifying** doctor needs to see the deceased 14 days before death, or after death. This has now been extended to allow for any doctor to have seen the deceased after death or within 28 days prior to death.

Video consultation (e.g. Skype) can be accepted for the purposes of 'being seen within 24 days. However, it cannot be used to see the body after death.

## CREMATION FORMS

1. The requirement to complete the **confirmatory** ("Part 2") medical certificate (form Cremation 5) is suspended. Cremations should be authorised on the basis of form Cremation 4 only.
2. Form Cremation 4 remains unchanged and a PDF version continues to be available here. It can be submitted electronically, and an electronic signature includes being sent from the secure email account of the person completing the form Cremation 4.
3. The requirement for form Cremation 4 to be completed by the attending medical practitioner is suspended. Any medical practitioner can now complete form Cremation 4, even if they did not attend the deceased during their last illness or after death, if the following conditions are fulfilled:
    i. The medical practitioner who did attend the deceased is unable to sign the form Cremation 4 or it is impractical for them to do so and,
    ii. A medical practitioner has seen the deceased (including audiovisual/video consultation) within 28 days before death or has viewed the body in person after death.
4. Examination of the body is not required for completion of form Cremation 4 if the deceased was seen by a medical practitioner (including audio-visual/video consultation) in the 28 days before death.
5. When a medical practitioner who did not attend the deceased completes form Cremation 4, the following applies:
    i. Question 5. 'Usual medical practitioner'. Where the certifying doctor did not themselves attend the patient either during their illness or after death, the certifying doctor should provide the GMC number and name of the medical practitioner who did
    ii. attend at Question 9. This should also include the date when the deceased was seen and a report of the record made by the attending doctor.
    iii. Question 6. 'Not applicable' is acceptable.
    iv. Question 7. 'Not applicable' is acceptable.
    v. Question 8. 'Not applicable' is acceptable. As at (iii) above, if the form Cremation 4 is being completed on the basis of another medical practitioner having seen the deceased after death, the date, time and nature of their examination should be recorded at Question 9.
6. Any completed cremation forms 5 that you may receive will not form part of the application and there will be no duty to retain them. There will be no need for a medical referee to re-authorise any cremation that they have already authorised under the arrangements.

## After death – handling the deceased and their effects

Following a patient's death, staff should **continue to wear PPE including Fluid Resistant Surgical Mask, apron, gloves and goggles/eye protection** when handling the body of the deceased, including laying out/last offices.

**Use of body bags is not a requirement** but may be practical for other reasons.

**The patient's belongings** can be returned to the Next of Kin in a **sealed plastic bag**; the bag must **not be opened for seven days** to ensure that the virus has died following any surface contamination of the possessions.

Link to specific guidance from NHS England is here, and from gov.uk is here.

## After death – information for families

- During the Covid-19 pandemic, families will need to register a death by telephone. They must phone to make an appointment: 01422 288080
- They will need to have the following information ready for the discussion.

| Details required | Guidance notes | Deceased details |
|---|---|---|
| Date of death | | |
| Place of death | This will be the name of the hospital or nursing home, the name or number of the house, the name of the street and village town etc.<br>If the death took place in an ambulance, car etc then please record circumstances i.e. the locality of the vehicle when the death occurred and the intended destination. | |
| Name and surname | This should be the name they were known as at the time of his or her death. You should also establish if they are known by any other name currently or previously. These too should be recorded with some notes as to the circumstances to help the registrar ascertain how to record the information in the entry. | |
| Sex | Male or Female | |
| Maiden surname of woman who has married | This is the surname in which a woman contracted her (first) marriage. | |
| Date of birth | Please provide approximate dates if exact date not known. | |
| Place of birth | Town and county/London borough or country of birth and only country if born outside UK. | |
| Occupation | Please provide as much information as possible relating to the most recent occupation.<br>Please also record whether the deceased was retired. | |
| Usual address | This should include the name or number of the house, name of the street and village or town. Where the death occurred in a hospital the deceased's usual address should be recorded. | |

**FUNERALS**

Families should be warned that mourners will not be able to attend cremations, and numbers of mourners at burials is restricted. (details can be seen here)

## Supporting family members to give PRN injections at home

Currently, there is no policy or agreed training process for this to be done in Calderdale.

If this situation changes, we will update this page of the document.

In the meantime, if your organisation is considering introducing a policy and training for family members, there is some useful information here:

https://subcut.helixcentre.com/