Northern Lincolnshire
Area Prescribing Committee

PAIN AND SYMPTOM MANAGEMENT GUIDANCE IN THE LAST DAYS OF LIFE

Version:	1.0
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Approval/Ratification body	Area Prescribing Committee (Northern Lincolnshire)
CQC outcome:	Outcome 9 Management of medicines
Date Reviewed/ratified:	17th February 2015
Subsequent Review date:	December 2017

1.0 Introduction

1.1 PRN (as required) medication for any potential symptom needs to be prescribed in anticipation immediately for care in the last days of life.

1.2 Drugs pre-emptively prescribed will vary according to the patient's existing medication, this guidance will help to provide general guidance for basic drug conversions to subcutaneous routes and prescribing for patients not on existing medications

1.3 All medication information is provided as a guide. Individual clinician's discretion should always be used when prescribing; this should take into account a comprehensive patient assessment which includes efficacy and adverse effects of medication choices.

Note: Within Palliative Care, medications are commonly used for conditions or in ways that are not specified on the licence and by other routes, for example medications may be given subcutaneously rather than Intravenously or intramuscular. Where there is off label use of medications within this guidance there is research and experience to support such use. Off label medications within this guideline are identified with ** for the prescribers awareness.

1.4 Always discuss the rationale for medications with the patient (where able) and the family.

1.5 Always consider non pharmacological approaches as per the patient's individual care plan.

1.6 For patients being discharged home from hospital please see Anticipatory Drug Prescribing Policy for the End of Life Care.

2.0 Aims and Objectives

The aim of this document is to ensure uniformity when considering/managing the patient's pain and other symptoms in the last days of life.

3.0 Area

This guidance is for use across Northern Lincolnshire within all areas where end of life care is provided.

PAIN

UNDERTAKE PAIN ASSESSMENT

Look for underlying cause and reverse if appropriate

Review current analgesia (including effect and side effects)

Patient is not currently taking any medication for pain

Prescribe in anticipation **Diamorphine s/c injection 1.25mg – 2.5mg (1-2 hourly)**
Titrate to effect/side effects

If 2-3 PRN doses are required – commence a syringe driver

Diamorphine 5mg – 10mg s/c over 24 hours (depending on PRN doses needed, their efficacy and adverse effects

N.B. Also maintain Diamorphine s/c injections for breakthrough pain.

Review and reassess pain every 24 hours as a minimum.

Patient taking ORAL MORPHINE

Convert oral Morphine dose to **Diamorphine** s/c
(i.e. 24 hour dose of Morphine divided by 3)
E.g.
Modified release Morphine 30mg bd = modified release Morphine 60mg in 24 hrs
Divide dose by 3 = **Diamorphine** 20mg s/c via a syringe driver over 24 hours.

Also prescribe PRN **Diamorphine** s/c for breakthrough pain by calculating one sixth of the dose in the driver.
E.g.
Diamorphine 20mg s/c in 24hrs via a driver will require **Diamorphine** 2.5mg - 5mg s/c PRN

Review and reassess pain every 24 hours as a minimum.

Patient on FENTANYL

Maintain **Fentanyl** patch at existing dose and prescribe **Diamorphine** s/c PRN in anticipation of breakthrough pain.
Calculate this dose by dividing the strength of the **Fentanyl** patch by 5
E.g.
If the **Fentanyl** patch dose is 25 micrograms per hour, the breakthrough **Diamorphine** dose will be 5mgs (25 ÷ 5 = 5)

If 2-3 PRN doses are required within 24 hours, commence **Diamorphine** s/c via a syringe driver over 24 hours.

Review and reassess pain every 24 hours as a minimum.

IF patient is receiving other strong opioids or SYMPTOMS PERSIST – Please contact the Macmillan / Palliative Care Team

PLEASE REFER TO SYRINGE DRIVER GUIDELINES

Respiratory Tract Secretions

ASSESS SYMPTOMS AND REVIEW CURRENT MEDICATION
Look for underlying cause and reverse if appropriate

ABSENT

Prescribe in anticipation as it is essential to commence treatment at the first sign of respiratory tract secretions

Glycopyrronium 200 micrograms S/C PRN

PRESENT

Try turning the patient first & explain to family that as they are semi – conscious / unconscious the patient may not be distressed by secretions

Immediately administer
Glycopyrronium 200 micrograms S/C injection

Commence syringe driver
Glycopyrronium 800 micrograms over 24 hours

Continue to administer S/C PRN dose as needed up to a maximum daily dose of 1200

IF SYMPTOMS PERSIST – Please contact the Macmillan / Palliative Care Team

PLEASE REFER TO SYRINGE DRIVER GUIDELINES

RESTLESSNESS AND AGITATION

ASSESS SYMPTOMS AND REVIEW CURRENT MEDICATION
Look for underlying cause and reverse if appropriate

ABSENT

Prescribe in anticipation **Midazolam** S/C 2.5mg – 5mg PRN

Optimise non-pharmacological measures

NB –It is important to exclude other treatable causes such as:

Full Bladder
Constipation
Pain
Environment
Anxiety
Sepsis

Drugs to relieve fear & anxiety

If the patient is able to take **Lorazepam** tablets 0.5mg (half 1 mg tablet) sublingually

If the patient cannot tolerate ****Lorazepam** as above give **Midazolam** 2.5mg-5mg S/C

PRESENT

Administer **Midazolam** 2.5mg – 5mg S/C. The dose may be repeated after a minimum of one hour if symptoms persist.

Reassess and if symptoms persist - commence **Midazolam** 5- 10mg S/C over 24 hours via a syringe driver

Continue with S/C PRN **Midazolam** dosage if needed to a total maximum of 30mg/24 hours

If symptoms persist reassess cause & seek advice from Palliative Care Team

2nd line

Levomepromazine 6.25mg
S/C PRN

May use **Levomepromazine** 12.5mg – 25mg S/C over 24 hours. This may be increased in 6.25 - 12.5mg S/C increments until the patient is calm.

Please refer to syringe driver guidelines for information regarding drug compatibilities.

IF SYMPTOMS PERSIST – Please contact the Macmillan Palliative Care Team

PLEASE REFER TO SYRINGE DRIVER GUIDELINES

DELIRIUM

Acute confused state characterised by cognitive impairment and mental clouding (may include hallucinations, aggression, plucking and increased or decreased psychomotor activity)

ABSENT

Prescribe in anticipation

****Haloperidol** 0.5mg – 1.5mg s/c PRN

PRESENT

1st Line
Administer initial dose of
****Haloperidol** 0.5mg -1.5mg s/c

If requires 2-3 PRN doses commence syringe driver with **Haloperidol** 1.5mg – 3mg S/C over 24 hours
Titrate up to a maximum of 5 - 10mg over 24hrs if required

2nd Line (if above ineffective or partly effective)
Continue **Haloperidol** and administer **Midazolam** 2.5mg – 5mg s/c

Add in syringe driver
Midazolam 5 - 10mg s/c over 24 hrs

If above ineffective, reassess cause and seek advice from Palliative Care Team

3rd Line
Consider **Levomepromazine** 6.25mg -12.5mg s/c instead of Haloperidol

Commence syringe driver with **Levomepromazine**12.5mg - 25mg S/C over 24hr

Optimise non-pharmacological measures

Assess for any underlying cause and reverse if appropriate. i.e. Drugs, infection, electrolytes etc.

Nurse in quiet well lit room with family presence if possible. Relieve physical factors and avoid precipitating situations such as change in environment

IF SYMPTOMS PERSIST – Please contact the Macmillan Palliative Care Team

PLEASE REFER TO SYRINGE DRIVER GUIDELINES

DYSPNOEA

ASSESS SYMPTOMS AND REVIEW CURRENT MEDICATION
Look for underlying cause and reverse if appropriate
OPTIMISE NON PHARMACOLOGICAL MEASURES

Is the patient requiring strong opioids (by any route) for analgesia/breathlessness?

NO

Prescribe in anticipation **Diamorphine** 1.25mg – 2.5mg s/c PRN (may be given 1-2 hourly if needed).

YES

Prescribe 1/20th of the 24 hour analgesic dose as a PRN dose (may be given 1-2 hourly)

Depending on effect, this dose may be titrated up to the full analgesic breakthrough dose.

E.g.
Patient is having **Diamorphine** 60mg s/c over 24 hours for pain.

Starting PRN dose for dyspnoea is:
Diamorphine 3mg s/c PRN which may be titrated up to:
Diamorphine 10mg s/c PRN depending on effect.

Drugs to relieve fear & anxiety

If the patient is able to take ****Lorazepam** tablets 0.5mg (half 1 mg tablet) sublingually

If the patient cannot tolerate ****Lorazepam** as above give **Midazolam** 2.5mg-5mg S/C PRN

IF SYMPTOMS PERSIST – Please contact the Macmillan Palliative Care Team

PLEASE REFER TO SYRINGE DRIVER GUIDELINES

NAUSEA AND / OR VOMITING

ASSESS SYMPTOMS AND REVIEW CURRENT MEDICATION
Look for underlying cause and reverse if appropriate

ABSENT	SYMPTOMS UNDER CONTROL	PRESENT
Prescribe in anticipation: **Haloperidol** 0.5mg - 1.5mg S/C PRN/4hrly (Maximum dose of 5mg in 24hrs)	Convert current oral dose to S/C **via a syringe driver over 24 hours**	Please refer to list of drugs for guidance as to the most appropriate anti-emetic Administer a S/C PRN dose of the most appropriate anti-emetic Commence the most appropriate anti-emetic S/C via a syringe driver over 24 hours starting at the lowest dose **If symptoms persist – it may be necessary to use a 2nd Anti-emetic. Reassess and see guidance on next page.** **May need to consider Levomepromazine** 6.25mg S/C PRN

IF SYMPTOMS PERSIST – Please contact the Macmillan Palliative Care Team

PLEASE REFER TO SYRINGE DRIVER GUIDELINES

PLEASE REFER TO SYRINGE DRIVER GUIDELINES FOR ANTI-EMETIC DRUG COMPATIBILITY

Following Assessment: Probable Cause of Nausea and / or Vomiting	Appropriate Drug	Recommended	
		PRN	24 hr dose via syringe driver
• Chemical Causes, e.g. hypercalcaemia or opiate induced	**HALOPERIDOL** (May be sedating)	0.5mg- 1.5mg S/C (maximum 5mg 24hrs)	1.5mg – 3mg (maximum 5mg 24hrs including PRN doses
• Gastric Stasis • Peristaltic Failure • Partial bowel obstruction **(without colic)**	**METOCLOPRAMIDE** (Non-sedating)	10mg S/C	30mg – 60mg
• Bowel obstruction with colic and / or need to reduce gastric secretions	**HYOSCINE BUTYLBROMIDE** (Minimal sedation) **OR**	20mg S/C	60mg – 120mg
	GLYCOPYRRONIUM (Minimal sedation)	200 micrograms	800 micrograms
• Raised intracranial pressure* • Complete bowel obstruction with colic (cyclizine inhibits the action of metoclopramide)	**CYCLIZINE** (May be sedating)	Up to 50mg TDS **If using a syringe driver - no PRN doses as 150mg is the maximum daily dose**	150mg (Maximum 24 hour dose)
• Where the probable cause cannot be ascertained after assessment or other anti-emetic drugs are ineffective	**LEVOMEPROMAZINE** (May be sedating)	6.25mg S/C	6.25mg – 12.5mg

*For raised intracranial pressure, high dose DEXAMETHASONE is also indicated.
Use a separate syringe driver or administer a once daily s/c dose (DEXAMETHASONE has a long duration of action)

PLEASE REFER TO SYRINGE DRIVER GUIDELINES

4.0 Associated Documents

4.1 One Chance to Get It Right. National Leadership Alliance (2014)

4.2 Care in the Last Days of Life Aide Memoire – Care Plus Group (2014)

4.3 Anticipatory Prescribing Sheet Care Plus Group & Yarborough Clee Care (2015)

4.4 Procedure For The Use Of The Syringe Driver In Palliative And End Of Life Care (Including Guidelines For Administration Of Drugs). 2013

5.0 References

All guidance adapted from:

- Palliative Care Adult Network Guidelines (2011)
- Dickman. A. (2011) Drugs in Palliative Care, Oxford University Press
- Twycross. R. Wilcock. A. (2011) Palliative Care Formulary, 4th Edition, Halstan Printing Group

6.0 Consultation

6.1 Dr Jason Boland, Consultant in Palliative Medicine. CPG & St Andrew's Hospice

6.2 Val Revill, Macmillan Lead Nurse & Clinical Lead for EoLC CPG

6.3 Rachel Staniforth, Pharmacy Advisor NEL CCG

6.4 Dr Anne Morris, Medical Director Lindsey Lodge Hospice.

6.5 Sue Cooper, Macmillan EoLC Clinical Care Facilitator NLAG

6.6 Northern Lincolnshire Area Prescribing Committee.

6.7 NEL CCG Clinical Leads Forum

7.0 Dissemination

7.1 Via the Northern Lincolnshire Area Prescribing Committee website.

7.2 All respective stakeholders including Care Plus Group, St Andrews Hospice, Lindsey Lodge Hospice, North and North East Lincolnshire CCGs

7.3 Via the NE Lincs CPG and End of Life Care website

7.4 Via the NLaG Trust Intranet.

7.5 Nursing & Midwifery Advisory Forum.

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8.0 Document History

None as this is a new guidance.

9.0 Equality Act (2010)

9.1 In accordance with the Equality Act (2010), each organisation will make reasonable adjustments to the workplace so that an employee with a disability, as covered under the Act, should not be at any substantial disadvantage. The organisation will endeavour to develop an environment within which individuals feel able to disclose any disability or condition which may have a long term and substantial effect on their ability to carry out their normal day to day activities.

9.2 The organisation will wherever practical make adjustments as deemed reasonable in light of an employee's specific circumstances and the organisation's available resources paying particular attention to the Disability Discrimination requirements and the Equality Act (2010).