PAIN AND SYMPTOM MANAGEMENT GUIDANCE IN THE LAST DAYS OF LIFE
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1.0 Introduction

1.1 PRN 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 medications; this guidance will help to provide general guidance for basic drug conversions to subcutaneous routes and prescribing for patients not on existing medications. For complex symptoms please refer to specialist palliative care teams for advice.

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 within all those areas where End of Life Care is provided.
4.0 PAIN

UNDOKE 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)
For Example:
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 taking ORAL OXYCODONE
Convert oral oxycodone dose to oxycodone s/c (i.e. 24 hour dose of oral Oxycodone divided by 2)
For Example:
Modified release oxycodone 30mg bd = modified release oxycodone 60mg in 24 hrs
Divide dose by 2 = Oxycodone 30mg s/c via a syringe driver over 24 hours.
Also prescribe prn oxycodone s/c for breakthrough pain by calculating one sixth of the dose in the driver. E.g.
Oxycodone 30mg s/c in 24hrs via a driver will require Oxycodone 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. (Continue Fentanyl patch)
Review and reassess pain every 24 hours as a minimum.

IF SYMPTOMS PERSIST – Please contact the Specialist Palliative Care Team

PLEASE REFER TO SYRINGE DRIVER GUIDELINES
5.0 **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 mcg

S/C PRN up to 2 hourly

maximum 6 doses/day

**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 mcg

S/C injection

Commence syringe driver

**Glycopyrronium** 800 mcg

over 24 hours

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

**IF SYMPTOMS PERSIST** – Please contact the Specialist Palliative Care Team

**PLEASE REFER TO SYRINGE DRIVER GUIDELINES**
6.0 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

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.

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 1mg tablet) sublingually

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

Exclude delirium (see separate entry)

IF SYMPTOMS PERSIST – Please contact the Specialist Palliative Care Team

PLEASE REFER TO SYRINGE DRIVER GUIDELINES
7.0 **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 up to 2 hourly maximum
10mg/24 hours

**PRESENT**

1\(^{st}\) Line Administer initial dose of **Haloperidol**
0.5mg - 1.5mg s/c PRN up to 2 hourly maximum
10mg/24 hours

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

2\(^{nd}\) 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

3\(^{rd}\) Line Consider **Levomepromazine** 6.25mg - 12.5mg s/c instead of Haloperidol

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

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**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

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**IF SYMPTOMS PERSIST** – Please contact the Specialist Palliative Care Team

**PLEASE REFER TO SYRINGE DRIVER GUIDELINES**
8.0 **DYSPNOEA**

### ASSESS SYMPTOMS AND REVIEW CURRENT MEDICATION

Look for underlying cause and reverse if appropriate

**OPTIMISE NON PHARMACOLOGICAL MEASURES**

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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).

**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

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**YES**

Prescribe 1/6th\(^{th}\) of the 24 hour analgesic dose as a prn dose (may be given 1-2 hourly)

**E.g.** Patient is having **Diamorphine** 30mg s/c over 24 hours for pain.

PRN dose for dyspnoea is:

**Diamorphine** 5mg s/c PRN 1- 2 hourly.

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**IF SYMPTOMS PERSIST – Please contact the Specialist Palliative Care Team**

**PLEASE REFER TO SYRINGE DRIVER GUIDELINES**
9.0 NAUSEA AND / OR VOMITING

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

ABSENT
Prescribe in anticipation:

Haloperidol 0.5mg - 1.5mg S/C PRN/4hrly
(Maximum dose of 5mg in 24hrs)

SYMPTOMS UNDER CONTROL
Convert current oral dose to S/C via a syringe driver over 24 hours

PRESENT
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 Specialist Palliative Care Team
PLEASE REFER TO SYRINGE DRIVER GUIDELINES
Following Assessment:
Probable Cause of Nausea and / or Vomiting | Appropriate Drug | Recommended
--- | --- | ---
• Chemical Causes, e.g. hypercalcaemia or opiate induced | **HALOPERIDOL** (May be sedating) | PRN | 24 hr dose via syringe driver
| | | 0.5mg - 1.5mg S/C (maximum 5mg 24hrs) | 1.5mg – 5mg (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) | 20mg S/C | 60mg – 120mg
| | **OR** | **GLYCOPHYLLOIDE** (Minimal sedation) | 200 micrograms | 800 - 1200 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 antiemetic 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)
10.0 Associated Documents

10.1 Care in the Last Days of Life Document – Northern Lincolnshire & Goole NHS Foundation Trust.

10.2 Anticipatory Drug Prescribing Policy for the End of Life Care.

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

11.0 References

All guidance adapted from:

- A guide to symptom management in palliative care: Yorkshire and Humber Palliative and End of Life Care Groups. Version 6 Published June 19 – review June 19

12.0 Consultation

12.1 Dr Yousef Adcock Consultant in Palliative Medicine.

12.2 Dr Lucy Adcock Director Lindsey Lodge Hospice.

12.3 Northern Lincolnshire Area Prescribing Committee.

12.4 NLAG End of Life Strategy Implementation Group.

12.5 North Lincolnshire Specialist Palliative Medicine Sub Group of the Multi-Agency End of Life Strategy Group.

12.6 NLAG Medicine and Therapeutic Committee

13.0 Dissemination

13.1 All adult wards – electronic version.


13.3 All ward managers – electronic version.

13.4 Hospital intranet.
14.0 Document History

Version 1.1. Minor changes. Updated analgesia and breathlessness guidelines to keep in line with anticipatory prescribing policy which has also been updated.

15.0 Equality Act (2010)

15.1 Northern Lincolnshire and Goole NHS Foundation Trust is committed to promoting a pro-active and inclusive approach to equality which supports and encourages an inclusive culture which values diversity.

15.2 The Trust is committed to building a workforce which is valued and whose diversity reflects the community it serves, allowing the Trust to deliver the best possible healthcare service to the community. In doing so, the Trust will enable all staff to achieve their full potential in an environment characterised by dignity and mutual respect.

15.3 The Trust aims to design and provide services, implement policies and make decisions that meet the diverse needs of our patients and their carers the general population we serve and our workforce, ensuring that none are placed at a disadvantage.

15.4 We therefore strive to ensure that in both employment and service provision no individual is discriminated against or treated less favourably by reason of age, disability, gender, pregnancy or maternity, marital status or civil partnership, race, religion or belief, sexual orientation or transgender (Equality Act 2010).

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