Derbyshire Symptom Management Guidance for the last days of life

Last updated May 2024 (version 6.2)

This guidance is intended for use when patients are recognised to be dying, in their last days.

For general symptom management guidance in palliative care please refer to other resources such as the Palliative Care Formulary or https://book.pallcare.info/

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If you require medical advice about symptom management, contact the Palliative Medicine Doctors

For the UHDB team, in working hours call 01332 788794 and the secretary will locate an available consultant. Out of hours call RDH switchboard 01332 340131 and ask for the Palliative Medicine consultant on-call. For the team at Ashgate Hospice during working hours contact 01246 568801.Out of hours call Chesterfield Royal Hospital switchboard and ask for the Palliative Medicine consultant on-call 01246 277271.

PRACTICAL TIPS FOR PRESCRIBING 'JUST IN CASE' OR 'ANTICIPATORY' MEDICATION

	Suggested starting dose PRN, can be given hourly. Review if more than 3 doses in 24 hrs
EITHER **Morphine (pain or breathlessness)** OR **Oxycodone (pain or breathlessness)**	**2.5 – 5mg** **1.25 - 2.5mg**
Midazolam (breathlessness or agitation)	**2.5mg**
EITHER **Haloperidol (nausea or agitation)** OR **Levomepromazine (nausea or agitation)**	**Nausea – 0.5-1.5mg** **Agitation – 1.5-3mg** Usual max 10mg/24h **6.25mg** Usual max 50mg/24h
EITHER **Hyoscine butylbrominde (secretions or abdominal colic)** OR **Glycopyrronium (secretions or abdominal colic)**	**20mg** Max 120mg/24h **200micrograms** Max 1200micrograms/24h
Don't forget the water for injection/NaCl 0.9% to re-constitute drugs &/or to make syringe driver up to final volume	If using 2 or more drugs in a syringe driver check compatibility guidance click here G268 - Palliative Care Syringe Driver - DCHS Medication Compatibility Guide.pdf (eolcare.uk). Advice can be sought from palliative care/pharmacy if doses are required that are outside DCHS guidance.

Preferred 'just in case' or 'anticipatory' medication sets vary by locality and across county borders. Prescribe medications you are familiar with, and which are available locally.

Usually, prescribe **one** opioid, midazolam, **one** treatment for agitation/nausea, **one** treatment for secretions/abdominal colic.

Starting doses suggested here are for use in a patient who has not previously used regular opioid, benzodiazepine, or antipsychotic medications.

If your patient is NOT opioid naïve – for example if they have a fentanyl patch or are taking MR morphine, refer to opioid equivalence chart on p4 to determine appropriate starting dose of morphine or oxycodone. Similarly, if they have been taking other medication (e.g. antipsychotic) regularly, a different PRN dose may be required.

Some symptoms can be controlled by measures other than medication - see flow charts p7-10. If symptoms are uncontrolled despite prn medication, it may be appropriate to increase prn doses by up to 50% and consider a syringe driver.

Most patients' symptoms will be controlled with a two or three drug combination in a single syringe. Seek advice if you are considering three or more drugs in combination or using two syringe drivers at the same time. DO NOT prescribe dose ranges of drugs for use in a syringe driver.

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EXAMPLE COMMUNITY ADMINISTRATION SHEET FOR JUST IN CASE MEDICATION

Blank template available at 1059_-_Palliative_Care_Just_in_Case_Anticipatory_Prescription_Information_Sheet__Patients_aged_18_years__older.docx (live.com)

UI	1059
Version No	8.4
Version Date	04/05/23
Review Date	9/6/25

'Just in Case' Anticipatory Drug Administration Instruction Sheet for Patients Aged 18 Years & Older

Surname MOUSE NHS No. 0000000000	Drug Allergies NKDA
Forename MICKEY DOB 12 / 3 / 1923	Details Date 1/2/34

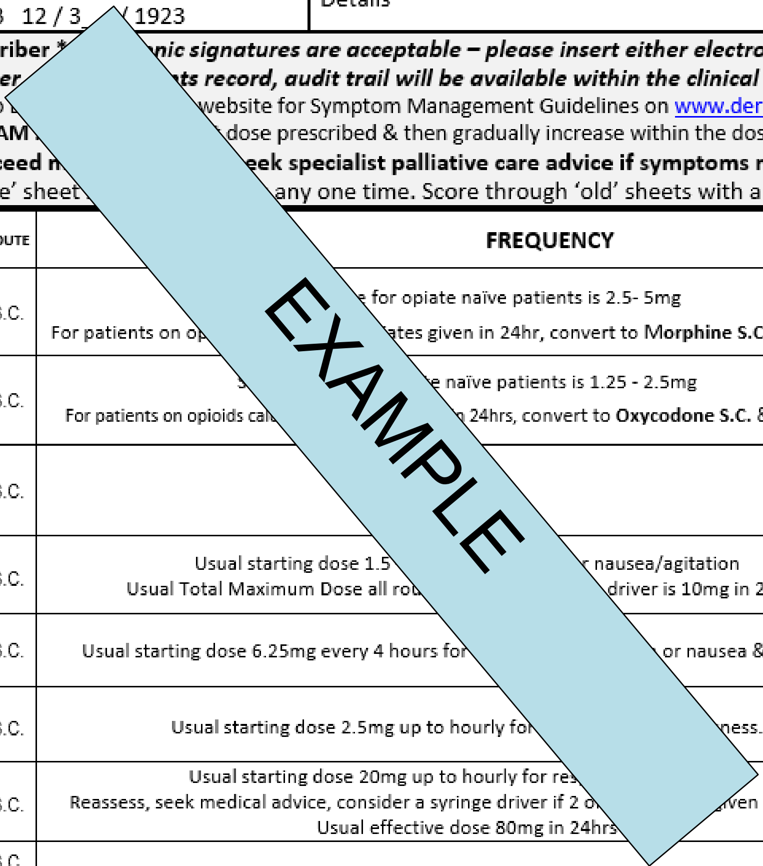
This form must be completed by a Prescriber **...nic signatures are acceptable – please insert either electronic signature or type name and registration number...ts record, audit trail will be available within the clinical system**

Please refer to ... website for Symptom Management Guidelines on www.derbyshire.eolcare.uk

ADVICE FOR ADMINISTRATION TEAM ... dose prescribed & then gradually increase within the dose range if symptoms are not controlled

Do not exceed m... eek specialist palliative care advice if symptoms not controlled.

ONLY a single 'Just in Case' sheet ... any one time. Score through 'old' sheets with a diagonal line and mark 'FILE'



DATE	DRUG	DOSE	ROUTE	FREQUENCY		PRESCRIBER Signature
1/2/34	Morphine Sulfate inj **FIRST LINE** OR	2.5 -5mg	S.C.	...for opiate naïve patients is 2.5- 5mg For patients on op... ...ates given in 24hr, convert to **Morphine S.C** & divide by 6	Up to hourly for pain or breathlessness. **If more than 3 doses in 12 hours seek medical advice**	Dr A Bee GP GMC 1234567
	Oxycodone inj OR		S.C.	...e naïve patients is 1.25 - 2.5mg For patients on opioids cal... ...n 24hrs, convert to **Oxycodone S.C.** & divide by 6		
	Alternative opioid		S.C.			
	Haloperidol inj OR	0.5mg	S.C.	Usual starting dose 1.5... ...r nausea/agitation Usual Total Maximum Dose all rou... ...driver is 10mg in 24 hrs	**If more than 3 doses in 12 hours seek medical advice**	Dr A Bee
	Levomepromazine inj		S.C.	Usual starting dose 6.25mg every 4 hours for... ...or nausea & vomiting.		
	Midazolam inj	2.5mg	S.C.	Usual starting dose 2.5mg up to hourly for... ...ness.	**If more than 3 doses in 12 hours seek medical advice**	Dr A Bee
	Hyoscine butylbromide inj	20mg	S.C.	Usual starting dose 20mg up to hourly for res... Reassess, seek medical advice, consider a syringe driver if 2 o... ...iven in 24 hours. Usual effective dose 80mg in 24hrs		Dr A Bee
	Specify other drug		S.C.			
	Water for injection (WFI)	As required	S.C.	To re-constitute drugs or use 0.5ml to flush cannula after a bolus		Dr A Bee

For DCHS completion	Name:	Confirm electronic completion checked and verified	Yes / No	Signature:	Date:

PRESCRIBING SUBCUTANEOUS OPIOID IN THE LAST DAYS OF LIFE

Is my patient already using a strong opioid? (e.g. morphine, oxycodone, fentanyl)
If my patient is using a transdermal patch such as fentanyl or buprenorphine, also see page 4.
If my patient has significant renal impairment, also see page 4.

YES

My patient is no longer able to manage their oral opioid. Convert to syringe driver!

Using Morphine syringe driver: Divide the total 24-hour oral morphine dose by TWO,
e.g. patient on 30mg Zomorph BD = 60mg oral morphine over 24 hours = 30mg morphine continuous s/c infusion over 24 hours.
If your patient has been using multiple prns for >48h consider including them in this dose calculation. Seek advice if unsure.

Using Oxycodone syringe driver: Divide the total 24-hour oral oxycodone dose by TWO,
e.g. patient on 30mg Oxycontin BD = 60mg oral oxycodone over 24 hours = 30mg oxycodone continuous s/c infusion over 24 hours.
If your patient has been using multiple prns for >48h consider including them in this dose calculation. Seek advice if unsure.

If you are switching between opiates, refer to Palliative Care Dose Equivalence Guidance (p6) and seek advice if unsure.

Diamorphine syringe driver should only be used where high doses of opioid required – in this instance please seek specialist advice.

NO

Prescribe anticipatory medication!
Morphine 2.5 - 5mg s.c prn up to hourly
Remember – if the patient can take sips, you may also use:
Morphine 5mg orally prn up to hourly

If the patient requires more than 3 prn doses within 4 hours, consider whether pain is opioid responsive. A medical review of analgesia may be needed.
If more than 3 doses need in 12 hours seek medical advice.

Reassess after 24 hours.
If pain persists and is opioid responsive, consider a syringe driver (see opposite)

Breakthrough Analgesia for patients managed with syringe drivers:

Morphine or oxycodone sc injection: divide 24-hour dose in syringe driver by SIX,
e.g. patient on 30mg morphine s/c over 24 hours = breakthrough dose of morphine 5mg s/c prn
e.g. patient on 30mg oxycodone s/c over 24 hours = breakthrough dose of oxycodone 5mg s/c prn

Morphine oral liquid (if the patient is taking sips of fluid): divide 24-hour dose in syringe driver by THREE,
e.g. patient on 30mg morphine s/c over 24 hours = breakthrough dose of morphine 10mg po prn

If using diamorphine in syringe driver – seek specialist advice.

To calculate subsequent doses of opioid

Review doses of prn analgesia given in last 24 hours.

If more than one dose has been required, other than to pre-empt during care, (e.g. before a dressing etc.) consider a 30% to 50% increase in syringe driver dose.

If this does not control pain or doses need escalating on a daily basis - seek specialist advice.

Note: Morphine = morphine sulphate

See also: https://book.pallcare.info/index.php?op=plugin&src=opiconv

PRESCRIBING OPIOIDS IN THE LAST DAYS OF LIFE

Transdermal Fentanyl/ Buprenorphine
If a patient is using transdermal opioid but now has uncontrolled pain, **give an immediate appropriate PRN dose of s/c opioid**, according to patch dose (see p4). **Continue the current patch, do not remove.**

If a patient requires more than 2 prn doses of opioid in 24h period in addition to their patch: options for ongoing management include adding a further transdermal patch OR adding a syringe driver with supplementary opioid. Take care to titrate PRN doses accurately; it is recommended that you seek specialist advice.

Renal impairment in the last days of life
Morphine, codeine, tramadol, and oxycodone are metabolised to active metabolites which are excreted by the kidneys. In renal failure, metabolites can accumulate and have the potential to cause opioid toxicity but there is considerable interpersonal variation. Symptoms of opioid toxicity can be reduced in some patients by switching to an alternative opioid such as fentanyl or alfentanil – but this is more important when considering long-acting opioids for patients with a prognosis of weeks or months than for the PRN doses for patient in their last hours of life.

In the last days of life if renal function is impaired:

1. Consider reducing the dose of morphine and increasing the prn dosing interval.
2. If a patient appears toxic, manage symptoms of toxicity using haloperidol for nausea and hallucinations and midazolam for myoclonus and consider a switch to alfentanil/ fentanyl.
3. For advice about prescribing alfentanil/ fentanyl **seek advice from your specialist palliative care team.** See also Palliative Care Network Guidelines (PANG) https://book.pallcare.info or the Palliative Care Formulary (PCF) (login via subscription to MedicinesComplete or membership of the Association for Palliative Medicine; or available in print)

Dose equivalence guidance for weak opioids
Tramadol
Tramadol po 100mg = Morphine po 10mg
Tramadol po 100mg four times daily (400mg/24 hours) = Morphine po 40mg/24 hours

Codeine
Codeine po 30mg = Morphine po 3 mg
Codeine po 60mg four times daily (240mg/24 hours) = Morphine po 24mg/24 hours

See also:
https://book.pallcare.info/index.php?op=plugin&src=opiconv

DOSE EQUIVALENCE GUIDANCE FOR STRONG OPIOIDS IN PALLIATIVE CARE

- These dose equivalents are approximate and may need to be adjusted according to individual response.
- If your patient requires more than the equivalent of 120mg oral morphine a day we recommend you seek specialist palliative care advice.
- If you are prescribing for a patient with renal failure, refer to p5.
- PRN doses should be titrated to effect – the doses in this table are indicative but if smaller doses are having effect, it is not necessary to titrate upwards.
- If you do not understand abbreviations in this table, seek specialist advice.

Total ORAL* MORPHINE *24 hour	***ORAL* MORPHINE** *Usual maximum* ***hourly prn dose***	***S.C.* MORPHINE** *Usual maximum* ***hourly prn dose****	***S.C.* MORPHINE *OVER 24 hours***	***Total ORAL* Oxycodone *24 hour***	***ORAL* Oxycodone *MR (Oxycontin)* dose to be *given twice daily***	***ORAL* Oxycodone *immediate release (Oxynorm)*** *Usual maximum* ***hourly prn dose***	***S.C.* Oxycodone** *Usual maximum* ***hourly prn dose****	***S.C.* Oxycodone *OVER 24 hours***	***Fentanyl patch 72 hourly#*** ***Dose in microgram per hour***	***Buprenorphine patch*** ***Dose in microgram per hour Prescribe patch by brand***
20mg	2.5mg	1.5mg	10mg	10mg	5mg	1.5mg	1mg	5mg	6	10 7 days)
30mg	5mg	2.5mg	15mg	15mg	5mg or 10mg	2.5mg	1.25mg	7.5mg	12	15 (7 days)
40mg	7.5mg	2.5mg	20mg	20mg	10mg	3mg	1.5mg	10mg	12	20 (7 days)
60 mg	10mg	5mg	30mg	30mg	15mg	5 mg	2.5mg	15 mg	25	30 (7 days)
90mg	15mg	7.5mg	45mg	45mg	20mg	7.5mg	4 mg	20mg	37(use 25 and 12)	Suggest use Fentanyl Patch
120 mg	20 mg	10mg	60mg	60mg	30mg	10 mg	5 mg	30mg	50	“
180 mg	30 mg	15mg	90mg	90 mg	45mg	15 mg	7.5 mg	45 mg	75	“
240 mg	40 mg	20mg	120mg	120 mg	60mg	20 mg	10 mg	60 mg	100	“

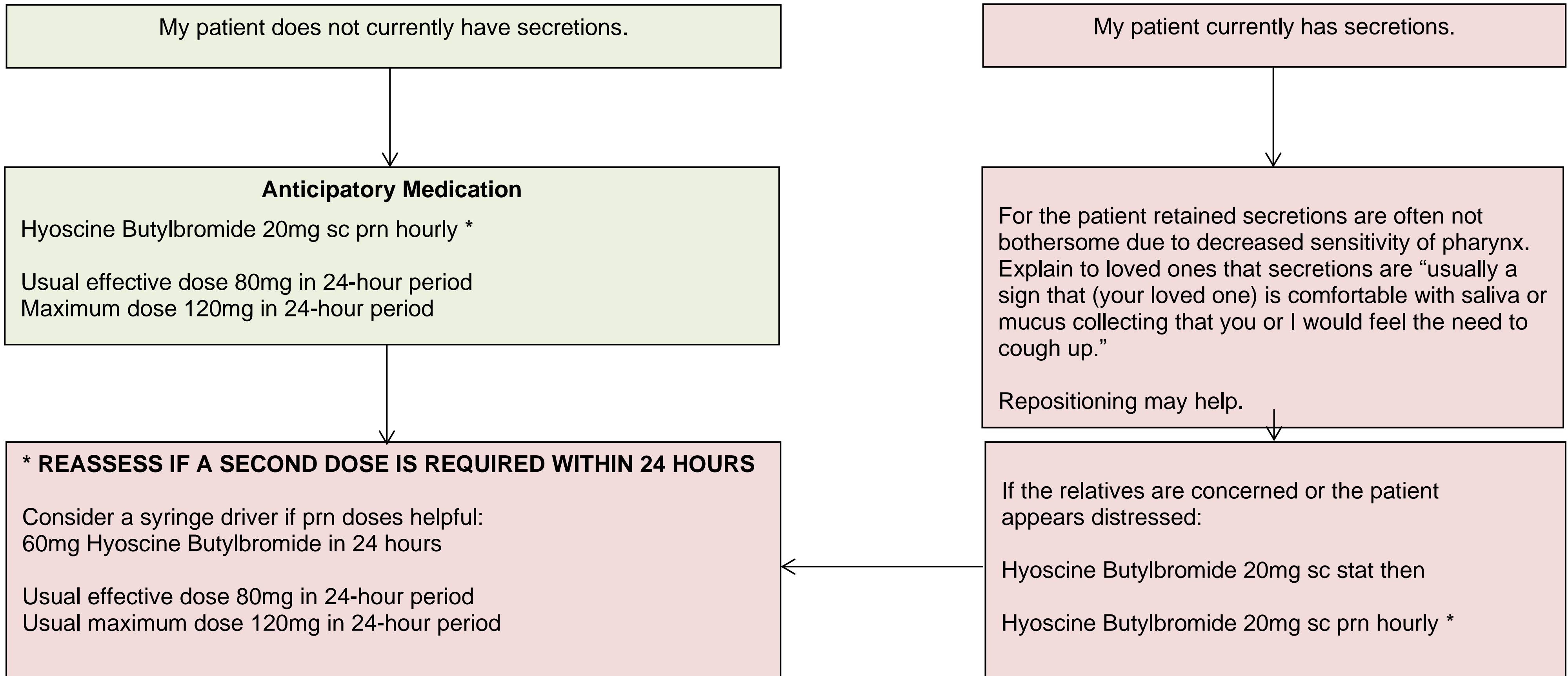
* Maximum **volume** of S.C bolus is **2ml**. As the maximum concentration of **morphine available is 30mg/ml** the maximum dose **morphine s.c bolus is 60mg**

 # This guidance is for converting from morphine to fentanyl. See Palliative Care Formulary PCF8 p448. If you are considering switching from fentanyl to morphine, we advise seeking specialist advice. See also *J Pain Symptom Manage. 1997 May;13(5):254-61. Transdermal fentanyl versus sustained-release oral morphine in cancer pain: preference, efficacy, and quality of life. The TTS-Fentanyl Comparative Trial Group. Ahmedzai S, Brooks D*

Note: Morphine = morphine sulphate

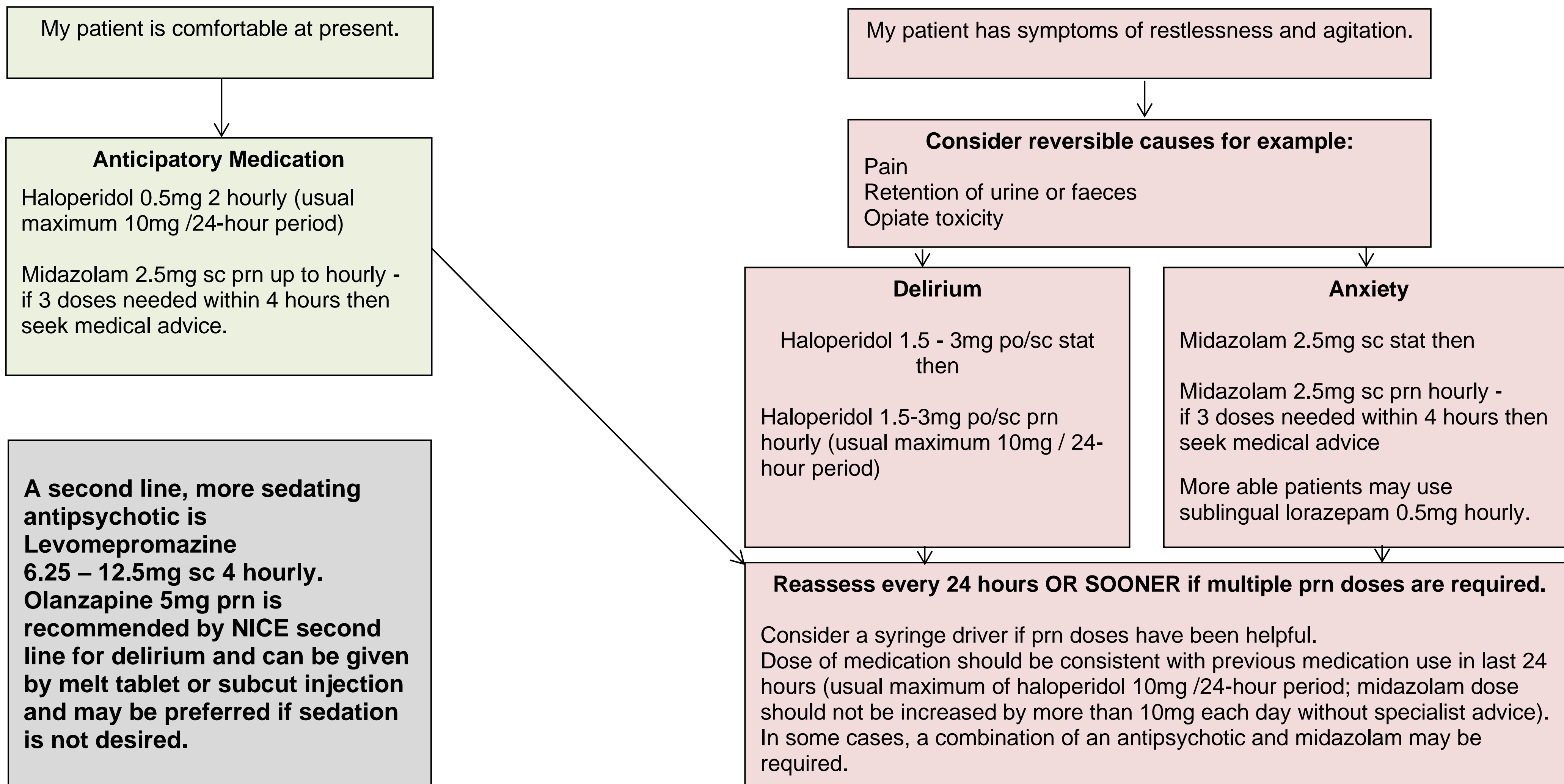
See also: https://book.pallcare.info/index.php?op=plugin&src=opiconv

RETAINED SECRETIONS IN THE LAST DAYS OF LIFE



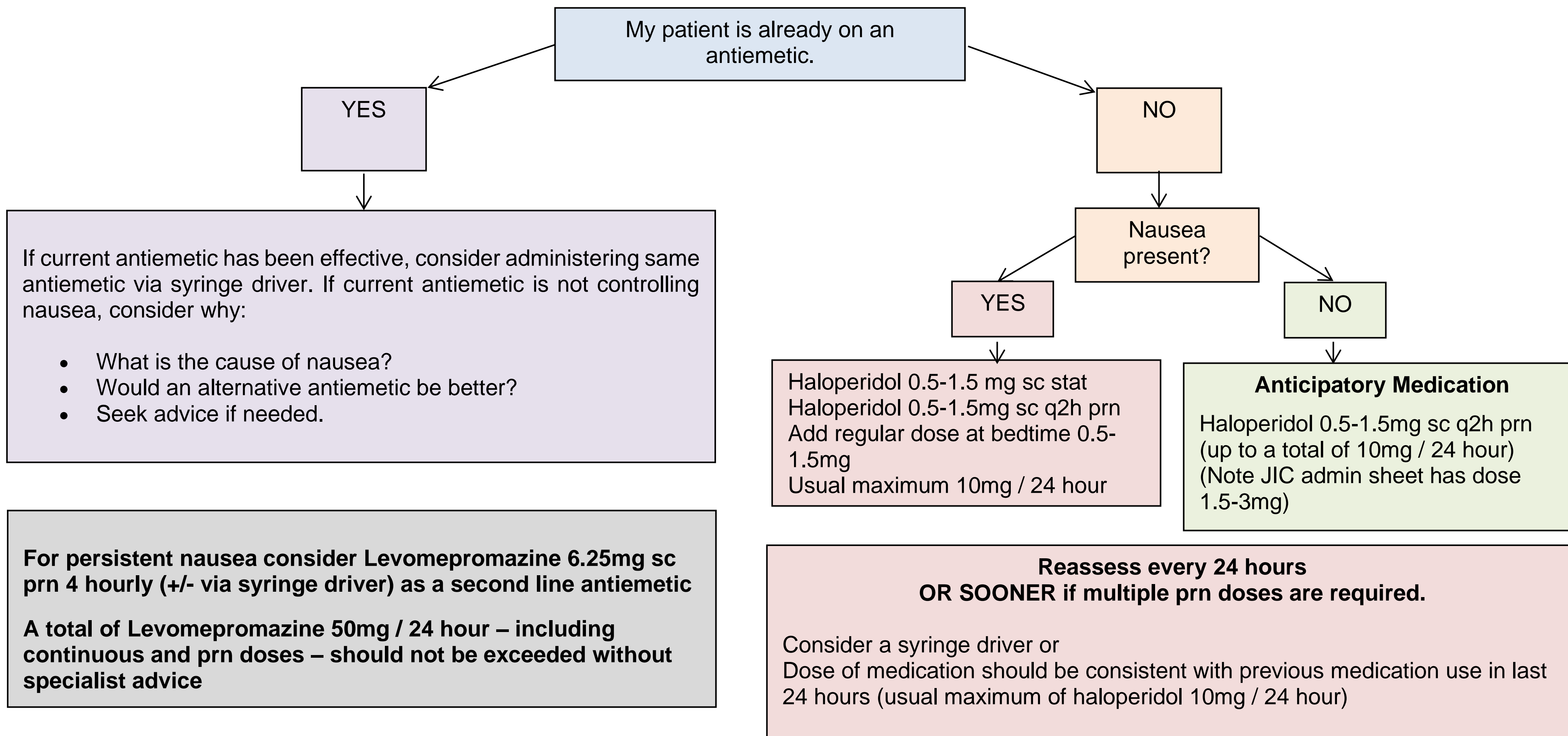
IF SYMPTOMS PERSIST – SEEK SPECIALIST ADVICE FROM YOUR PALLIATIVE CARE TEAM

RESTLESSNESS AND AGITATION IN LAST DAYS OF LIFE



IF SYMPTOMS PERSIST – SEEK SPECIALIST ADVICE FROM YOUR PALLIATIVE CARE TEAM

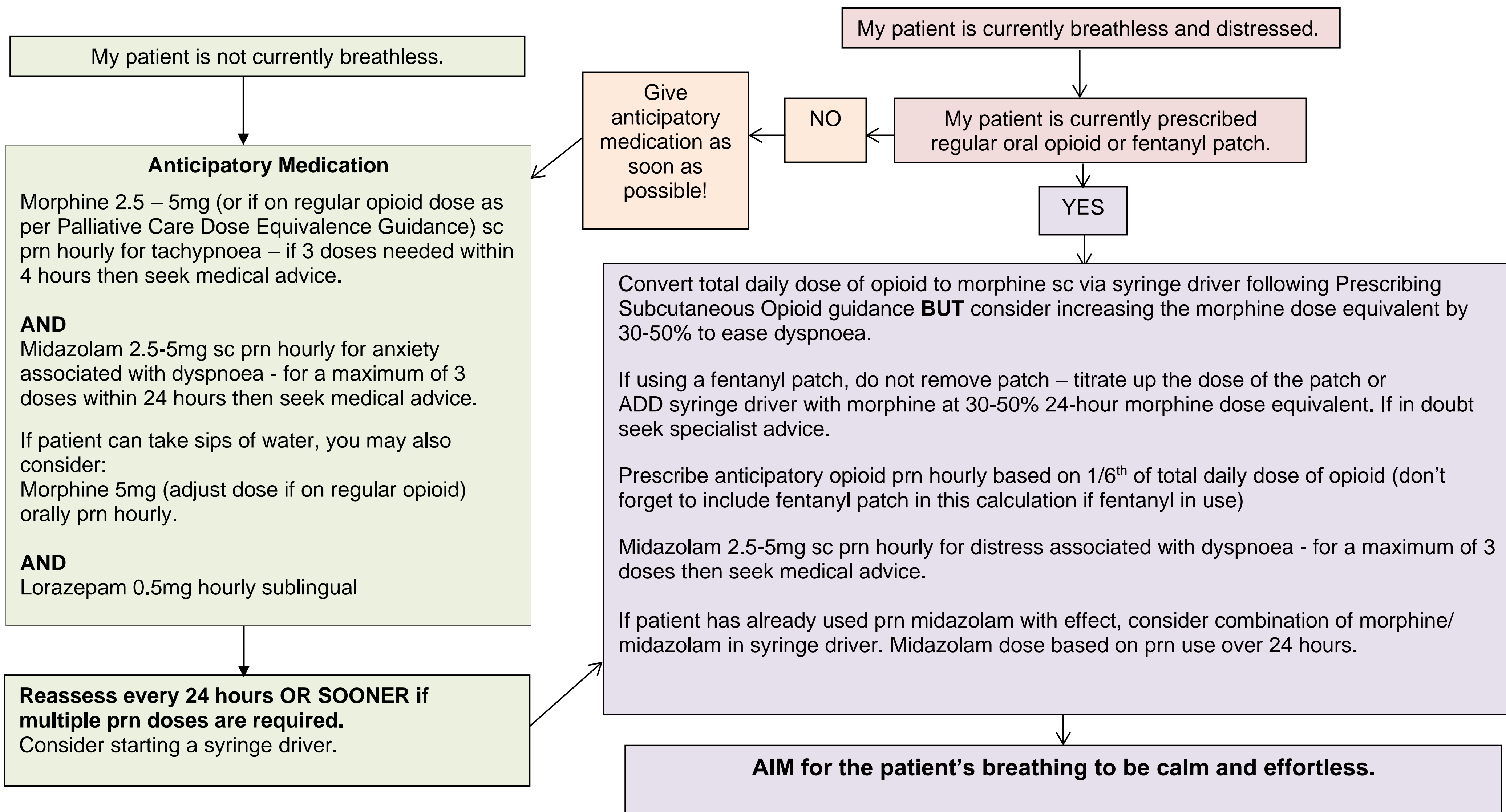
NAUSEA IN THE LAST DAYS OF LIFE



Note - For patients with **Parkinsons Disease**, Cyclizine 25-50mg PRN tds is preferred to Haloperidol or Levomepromazine

IF SYMPTOMS PERSIST – SEEK SPECIALIST ADVICE FROM YOUR PALLIATIVE CARE TEAM

BREATHLESSNESS IN THE LAST DAYS OF LIFE



IF SYMPTOMS PERSIST – SEEK SPECIALIST ADVICE FROM YOUR PALLIATIVE CARE TEAM

Note: Morphine = morphine sulphate

GUIDELINES FOR CARE OF DIABETIC PATIENTS IN THE LAST DAYS OF LIFE

Comprehensive guidance about treating diabetes in dying patients is available -EoL_TREND_FINAL2_0.pdf (amazonaws.com)

Practical points:-

1. Ensure any clinical deterioration is not due to reversible hyperglycaemia or hypoglycaemia before making further management decisions particularly if the deterioration is unexpected.

2. Regularly review the patient and their diabetes management plan as their condition changes in the **last year** of life.

3. If your patient is in the **last WEEKS** of life, the aim of treatment is to avoid symptoms of hyperglycaemia and hypoglycaemia, tight glycaemic control is not necessary - see EoL_TREND_FINAL2_0.pdf (amazonaws.com) pages 10-13

4. If a patient has been recognised to be dying and believed to be in the **last DAYS** of life, insulin and oral agents can usually be stopped in patients with type 2 diabetes EoL_TREND_FINAL2_0.pdf (amazonaws.com)**- see page 21 Algorithm for last days of life**

   a. Blood or urine glucose monitoring should be kept to the minimum necessary and stopped if causing distress to the patient.

   b. If death imminent i.e. expected in less than 24 hours, it may be appropriate to discontinue all monitoring and insulin, usually after discussion with the family.

5. **SEEK SPECIALIST ADVICE IF UNCERTAIN**

- Your local Palliative Care Medical Team (see p1) or your local Diabetes Specialist Team