PRESCRIBING GUIDELINES FOR SYMPTOM MANAGEMENT IN THE DYING PATIENT

This guidance is only to be used by appropriately trained staff. All staff must work within the limits of their competency.

For advice and guidance on any aspect of caring for palliative patients or patients at the end of life please contact:

- 24 Hour Palliative Care Advice Line (for Health Professionals) 0844 225 0677
- Macmillan Community Specialist Palliative Care Team (based within Halton Haven Hospice) 01928 714927 (Monday to Sunday 9-5pm)

Version 1.0

Ratified: September 2019

Review Date: August 2021

Developed and Ratified by NHS Halton CCG, Bridgewater Community Healthcare NHS Foundation Trust and Halton Haven Hospice

This guidance has been developed as a tool to support safe and effective prescribing of medication that alleviates the common symptoms that occur in the dying patient.

1. Pain
2. Nausea and Vomiting
3. Agitation
4. Respiratory Tract Secretions
5. Breathlessness
6. Seizures

Most patients who are dying will experience one or more of these symptoms and will require medication that is administered subcutaneously either PRN or via a syringe driver. The IV or IM routes are not routinely recommended in the dying patient.

Conditions other than those stated above may also be experienced but are considered to be less common and therefore specialist advice is required e.g. Superior Vena Cava Obstruction (SVCO).

Always seek specialist advice for patients with renal impairment or renal failure.

It is good practice to prescribe PRN medication in advance of the last few days of life. This prevents delays in patients receiving medication.

Suggested strengths and quantities of **standard as required medication** prescribed in anticipation.

CYCLIZINE	50mg/1ml amps x **10**
MIDAZOLAM	5mg/ml 2ml amps (10mg/2ml) x **10**
GLYCOPYRRONIUM	200 micrograms/ml amps x **20**
WATER FOR INJECTIONS	10ml amps x **20**
MORPHINE	10mg/1ml amps x **10**
OR	
DIAMORPHINE	5mg amps x **10**

For patients who have epilepsy or have experienced seizures and are no longer able to take oral medication commence a syringe driver with 20mg **Midazolam** over 24 hours to prevent seizures. Ensure **Midazolam** 5mg SC PRN is also prescribed in addition for seizures. Please note higher doses may be required but please seek specialist advice in this scenario.

Where patients have been prescribed **Dexamethasone** please seek specialist palliative care advice before proceeding further.

Off-Licence Use of Medicines for End of Life or Palliative Care

There are clinical situations when the use of medicines outside the terms of the licence ('off-licence') may be judged by the prescriber to be in the best interests of the patient on the basis of available evidence. Such practice is common in end of life situations. Using a medication off-licence has implications for both prescribers and associated healthcare professionals so if there are any concerns regarding use of a specific medication at the end of life then it is important to seek specialist palliative care advice prior to prescribing or administering.

24 Hour Palliative Care Advice Line (for Health Professionals)
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PAIN MANAGEMENT - Morphine
Patient established on oral morphine or opioid naive.

Important: It is the responsibility of the prescriber to ensure that guidelines are followed when prescribing opioids. Every member of the team has a responsibility to check that the intended dose is safe for the individual patient. Knowledge of previous opioid dose is essential for the safe use of these products. Advice should be sought if prescribing outside of these guidelines or when the limits of own expertise are reached (NPSA/2008/RRR05).

CONTACT THE PALLIATIVE CARE TEAM (Details below) FOR ADVICE IF:
- The patient has moderate to severe renal failure.
- The patient has new severe pain or pain that has persisted after 24 hours on a syringe driver.

PATIENT IS TAKING ORAL MORPHINE

YES

- Stop all **Oral Morphine –** ensure patient/family aware that oral opioids have been stopped.
- Convert total daily dose of **Oral Morphine** to **Morphine Subcutaneous route** by dividing by 2 and prescribe this dose subcutaneously via a syringe driver over 24 hours (see example below).
- Prescribe a breakthrough pain dose of **Morphine** that is 1/6th of the calculated total **Morphine** dose IN SYRINGE DRIVER, SC PRN hourly (see example (below). If frequent doses required seek specialist advice.
- Reassess after 24 hours.

- If patient has required additional **Morphine** for breakthrough pain calculate total dose given over 24 hours and increase dose in syringe driver by 50% of this amount. DO NOT increase the syringe driver dose by more than 50% without seeking specialist advice.
- Ensure breakthrough dose remains at 1/6th of syringe driver dose.

NO

Patient has pain

YES

- Prescribe and give **Morphine** 2.5 mg-5 mg SC STAT.
- Prescribe **Morphine** 10 mg via syringe driver over 24 hours.
- Prescribe **Morphine** 2.5-5 mg SC PRN hourly for breakthrough pain.
- Reassess after 24 hours.

NO

Prescribe in anticipation of symptom **Morphine** 2.5 mg-5 mg SC PRN hourly.

KEY
SC= Subcutaneous
PRN = as required
STAT = immediately

Example

Syringe driver dose

Converting from oral Morphine to syringe driver
e.g. **Zomorph** 60 mg 12 hourly = 120 mg
120mg/2 = 60 mg
Dose of **Morphine** subcutaneously via syringe driver over 24 hours = 60 mg

Calculating breakthrough dose

The breakthrough dose is 1/6 th of total daily **Morphine** dose
Patient requires 60 mg **Morphine** via syringe driver over 24 hours
60mg/6 = 10 mg
Dose of **Morphine for breakthrough pain** SC PRN = 10mg

REMEMBER TO PRESCRIBE WATER FOR INJECTION

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PAIN MANAGEMENT – Diamorphine
Patient established on oral morphine or opioid naive.

Important: It is the responsibility of the prescriber to ensure that guidelines are followed when prescribing opioids. Every member of the team has a responsibility to check that the intended dose is safe for the individual patient. Knowledge of previous opioid dose is essential for the safe use of these products. Advice should be sought if prescribing outside of these guidelines or when the limits of own expertise are reached (NPSA/2008/RRR05).

CONTACT THE PALLIATIVE CARE TEAM (Details below) FOR ADVICE IF:
- The patient has moderate to severe renal failure.
- The patient has new severe pain or pain that has persisted after 24 hours on a syringe driver.

PATIENT IS TAKING ORAL MORPHINE

YES

- Stop all **Oral Morphine -** ensure patient/family aware that oral opioids have been stopped.
- Convert total daily dose of **Oral Morphine** to **Diamorphine Subcutaneous route** by dividing by 3 (three) and prescribe this dose subcutaneously via a syringe driver over 24 hours (see example below).
- Prescribe a **breakthrough** pain dose of **Diamorphine** that is 1/6th of the calculated total **Diamorphine** dose IN SYRINGE DRIVER, SC PRN hourly (see example below).(Commence at 2.5mg). If frequent doses required seek specialist advice.

- If patient has required additional **Diamorphine** for breakthrough pain calculate total dose given over 24 hours and increase dose in syringe driver by 50% of this amount. DO NOT increase the syringe driver dose by more than 50% without seeking specialist advice.
- Ensure breakthrough dose remains at 1/6th of syringe driver dose.

NO

Patient has pain

YES

- Prescribe and give **Diamorphine** 2.5 mg-5 mg SC STAT.
- Prescribe **Diamorphine** 7.5 mg via syringe driver over 24 hours.
- Prescribe **Diamorphine** 2.5-5 mg SC PRN hourly for breakthrough pain.

NO

Prescribe in anticipation of symptom **Diamorphine** 2.5 mg-5 mg SC PRN hourly.

KEY
SC= Subcutaneous
PRN = as required
STAT = immediately

Example
Syringe driver dose
Converting from **Oral Morphine** to syringe driver
e.g. **Zomorph** 60 mg 12 hourly = 120 mg
120mg/3= 40 mg
Diamorphine subcutaneously via syringe driver over 24 hours = 40 mg

Calculating breakthrough dose
The breakthrough dose is 1/6 th of total daily **Diamorphine** dose
Patient requires 40 mg via syringe driver over 24 hours
40mg/6 = 6.66mg
Local specialists recommend rounding down so **Diamorphine** SC PRN for breakthrough pain = 6mg

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PAIN MANAGEMENT
Patient established on Fentanyl Patches

Important: It is the responsibility of the prescriber to ensure that guidelines are followed when prescribing opioids. Every member of the team has a responsibility to check that the intended dose is safe for the individual patient. Knowledge of previous opioid dose is essential for the safe use of these products. Advice should be sought if prescribing outside of these guidelines or when the limits of own expertise are reached (NPSA/2008/RRR05).

- **DO NOT COMMENCE FENTANYL PATCHES FOR PAIN RELIEF IN THE DYING PHASE.**
- **If the patient has severe renal impairment and requires additional pain relief seek specialist advice on prescribing from the palliative care team.**

Important: For other transdermal analgesic preparations such as **Buprenorphine**, leave patch in situ, continue to re-apply as normal and seek specialist advice.

FENTANYL ESTABLISHED

DO NOT remove **Fentanyl** Patch continue and re-apply every 72 hours.
Ensure family/carers are aware that this is to continue.

PAIN PRESENT

- Prescribe adequate dose of breakthrough opioid analgesia as table on page 6.
- Re-assess after 24 Hrs.
- If 2 or more doses of breakthrough opioid are required in 24 hrs commence syringe driver. Prescribe **50%** of the total amount of breakthrough given in previous 24hrs via syringe driver **in addition to Fentanyl patch**.

PAIN CONTROLLED
Prescribe opioid for breakthrough pain as needed.
See table on page 6.

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PRN = as required

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Subcutaneous (SC) PRN doses for patients on Fentanyl patches

Fentanyl patch (microgram/hour)	Up to hourly Morphine SC PRN dose (mg)	Up to hourly Diamorphine SC PRN dose (mg)	Up to hourly Oxycodone SC PRN dose
12	2.5	1.25	1.25
25	5	2.5	2.5
37	7.5	5	5
50	10	5	5
62	12.5	7.5	7.5
75	15	10	10
100	20	12.5	12.5
125	25	15	15
150	30	20	20
175	35	25	25
200	40	25	25
225	45	30	30
250	50	35	35
275	55	35	35
300	60	40	40

(Dose ratio **Oral Morphine** to **Transdermal Fentanyl** 100:1 but this is a guide only, seek specialist advice if in doubt.)

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PAIN MANAGEMENT

For patients established on oral Oxycodone

Important: It is the responsibility of the prescriber to ensure that guidelines are followed when prescribing opioids. Every member of the team has a responsibility to check that the intended dose is safe for the individual patient. Knowledge of previous opioid dose is essential for the safe use of these products. Advice should be sought if prescribing outside of these guidelines or when the limits of own expertise are reached (NPSA/2008/RRR05).

- **BOTH 3:2 AND 2:1 CONVERSIONS FROM ORAL OXYCODONE TO THE SUBCUTANEOUS ROUTE ARE USED.**
- **IT HAS BEEN AGREED LOCALLY THAT 2:1 IS THE SAFEST OPTION FOR NON-SPECIALISTS. SEE BELOW.**

CONTACT THE PALLIATIVE CARE TEAM (details below) FOR ADVICE IF the patient is unable to tolerate or is allergic to Morphine/Diamorphine.

CONVERT ORAL OXYCODONE TO SUBCUTANEOUS ROUTE AS BELOW

- **CALCULATE DOSE REQUIRED OVER 24 HOURS IN SYRINGE DRIVER:**
  SYRINGE DRIVER DOSE = ½ OF ORAL DAILY DOSE.
  E.g. **Oxycontin 45** mg 12 hourly = 90 mg
  ½ of 90 mg = 45 mg
  Dose required in syringe driver = 45 mg
- **CALCULATE DOSE OF OXYCODONE REQUIRED FOR RELIEF OF BREAKTHROUGH PAIN.**
  BREAKTHROUGH DOSE = 1/6TH DOSE IN SYRINGE DRIVER.
  E.g. **Oxycodone** 45mg/24 hours in syringe driver =7.5mg **Oxycodone** SC PRN hourly.
- **RE-ASSESS AFTER 24HRS –** if patient has required breakthrough analgesia calculate total amount given in previous 24 hrs and increase dose in syringe driver by **50%** of this amount.
- **ENSURE THAT BREAKTHROUGH DOSE REMAINS 1/6th of DOSE IN SYRINGE DRIVER.**

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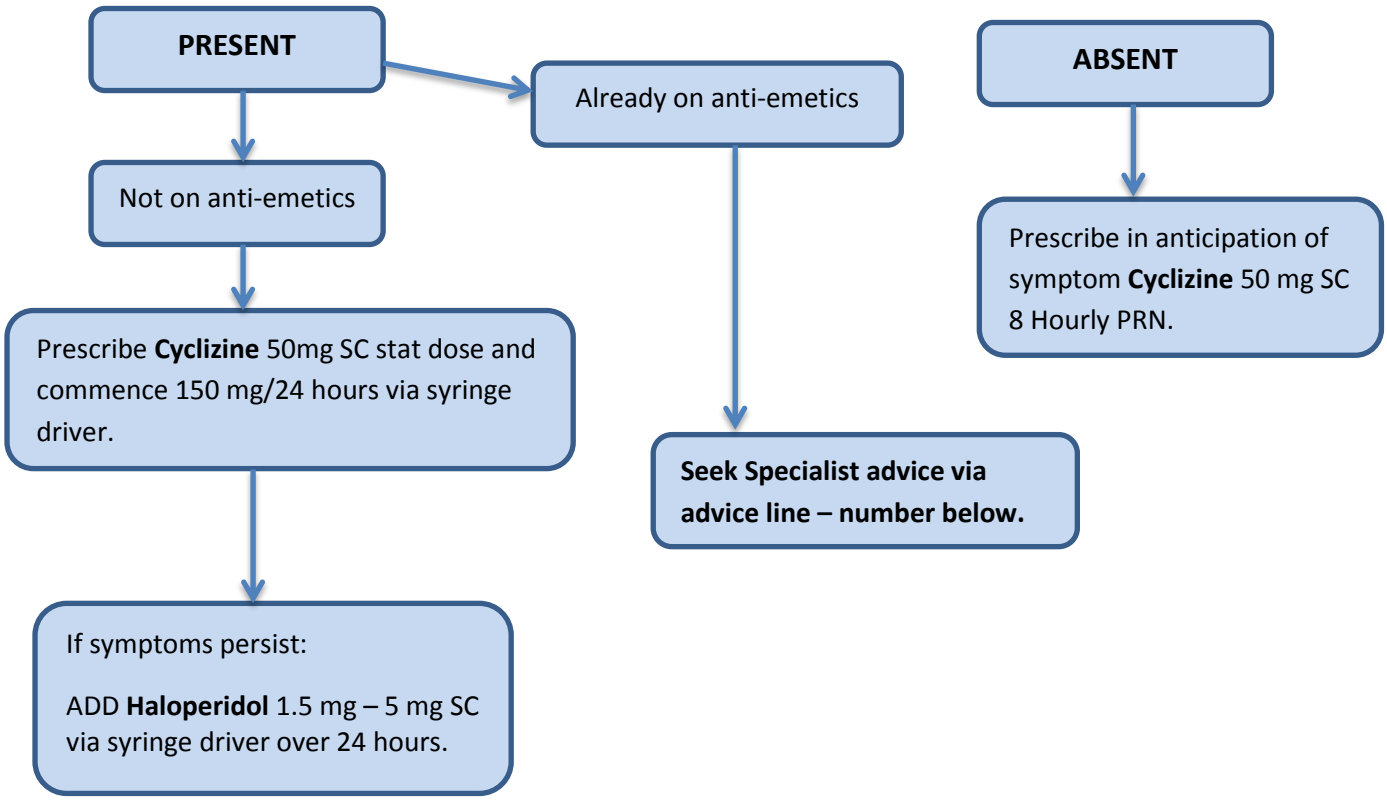
NAUSEA & VOMITING



PATIENTS WITH HEART FAILURE

CYCLIZINE IS NOT RECOMMENDED IN PATIENTS WITH END STAGE HEART FAILURE but it may occasionally be used following specialist advice ONLY.

Alternative anti-emetics following specialist advice:
Haloperidol *1.5mg – 3mg SC PRN 8 hourly*
1.5mg-5mg via a syringe driver over 24 hours; maximum 10mg/24 hours.
OR
Levomepromazine 6.25mg SC PRN 6 hourly or
6.25 mg – 25 mg via a syringe driver over 24 hrs.

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TERMINAL RESTLESSNESS & AGITATION

The intention of sedation in palliative care is to relieve distress – unconsciousness may occur but is not a desired outcome (refer to NPSA/2008/RRR011)

For the purpose of this guidance agitation and delirium are defined as follows;

Agitation - Mental distress causing restlessness.

Delirium - Acute confusion causing restlessness.

PRESENT

Urinary retention and rectal distension from constipation are common reversible causes of agitation – ensure these and any other causes are excluded.

If delirium is suspected please contact the Specialist Palliative Care Team for advice.

If the patient is currently on anxiolytics or hypnotics then please seek specialist advice.

- Prescribe **Midazolam** 2.5 mg – 5 mg SC PRN up to hourly and **Midazolam** 10-20mg SC via syringe driver over 24 hours.
- Administer 2.5mg of **Midazolam**, if 2.5 mg ineffective after 30 minutes, give a further 2.5mg. If patient remains agitated seek medical review and contact Specialist Palliative Care Team for advice.
- If agitation likely to persist commence **Midazolam** 10 mg-20 mg SC via Syringe Driver over 24 hours.

To calculate the subsequent subcutaneous dose of **Midazolam** over 24 hours:

- Calculate and add total dose of **Midazolam** given on a PRN basis over previous 24 hours to current 24 hour dose via syringe driver.
- Increase the dose of **Midazolam** accordingly up to **30 mg** in **syringe driver** over 24 hours.
- Continue with PRN **Midazolam** – calculate dose as 1/6th of syringe driver dose.

If Midazolam 30 mg in syringe driver is reached and symptoms are not controlled, please seek advice as higher doses may be appropriate.

ABSENT

Prescribe **in anticipation** of symptom **Midazolam** 2.5 mg – 5mg SC up to hourly PRN.

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RESPIRATORY TRACT SECRETIONS

Practical Point: Patients can't clear secretions from their upper respiratory tract properly causing secretions to move as they breathe, creating noise. The patient is usually unconscious at this stage and unaware this is happening. A discussion with the family or carer is helpful to reassure them.

It is important to start treatment as soon as symptoms occur.

NON-PHARMACOLOGICAL OPTIONS:

- **Reposition Patient**
- **Active surveillance**
- **Reassurance and explanation**

Anticipatory prescribing for all patients:

- **Glycopyrronium** 200microgram SC PRN single dose. (once a SC single dose is given, please commence the CSCI with **Glycopyrronium**)
- **Glycopyrronium** 600-1200microgram SC over 24 hours in syringe driver; Maximum 1200 micrograms in 24 hours.

If the patient experiences respiratory secretions:

- Identify and treat the cause if possible.
- Use appropriate non-pharmacological methods – see below.
- If the patient is still experiencing respiratory secretions administer 200 microgram **Glycopyrronium** SC AND commence syringe driver containing 600microgram **Glycopyrronium** over 24 hours.
- Medication will prevent new secretions being produced but will not remove secretions already present.
- Monitor for efficacy and side effects at least every 24 hours.
- Anti-cholinergic side effects can arise; treat this with frequent mouth care which may include artificial saliva replacement gels or sprays.
- If not responding, seek specialist advice.

If respiratory secretions persist over the next 24 hours:

- Increase syringe pump to 1200 microgram **Glycopyrronium** over 24 hours.
- If symptoms persist seek specialist advice.
- The total daily dose of **Glycopyrronium** including PRN doses should not exceed 1200 microgram without specialist advice.

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BREATHLESSNESS

DISTRESSING BREATHLESSNESS

YES

- **Prescribe Morphine 2.5 mg -5 mg SC 4 hourly PRN & Midazolam 2.5 mg SC 4 hourly.**

State on drug chart that indication is breathlessness

Or

If breathlessness is constant

- **Prescribe PRN Morphine** 5 mg -10 mg via syringe driver over 24 hours (if previously taking oral opioid for breathlessness convert previous oral opioids dose). (See pain algorithm).
  &
  Midazolam 5 mg-10 mg via syringe driver over 24 hours.

NO

Prescribe PRN opioids & anxiolytic in anticipation of symptoms.

Morphine 2.5 mg SC 4 hourly PRN

AND

Midazolam 2.5 mg SC 4 hourly PRN.

Patients currently using strong opioid for pain:

- If a patient is already established on a different opioid e.g. **Diamorphine** or **Oxycodone,** please seek specialist advice.
- If already using **Morphine**, increase strong opioid dose by 33% to cover the symptom of breathlessness.
- Doses should be rounded up or down to the nearest practical dose to administer.
- **If there are any concerns or doubts about how to progress please seek specialist advice.**

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SEIZURES – Management in the Dying Phase

ADVANCE PLANNING:

If a patient is established on Anti-epileptic Drugs (AEDs), adequate planning should take place in advance for when the patient is no longer able to take oral medication.

Patients on Levetiracetam - Please seek specialist advice.

ACUTE SEIZURES

- May settle spontaneously.
- Ensure airway secure and administer **Oxygen** if available.
- If seizure does not stop within 5 minutes give buccal or subcutaneous **Midazolam** 5mg.

IF SEIZURES CONTINUE despite above measures, if at home/nursing home;

- Repeat dose of the **Midazolam** used after 10 minutes and seek specialist advice.
- Decide if transfer to hospital for emergency management is needed or if care will continue in the current care setting.
- If patient to stay in current care setting and two doses of midazolam have been administered consider a continuous subcutaneous infusion of **Midazolam** 10mg - 30mg over 24 hours. This is a suggested starting dose and specialist will advise regarding use of higher doses.

For patients who have epilepsy or have experienced seizures and are no longer able to take oral medication commence a syringe driver with 20mg **Midazolam** over 24 hours to prevent seizures. Ensure **Midazolam** 5mg - 10mg SC PRN is also prescribed in addition for continuing seizures.

Please note higher doses may be required but please seek specialist advice in the scenario where more than 30mg **Midazolam** is used in 24 hours.

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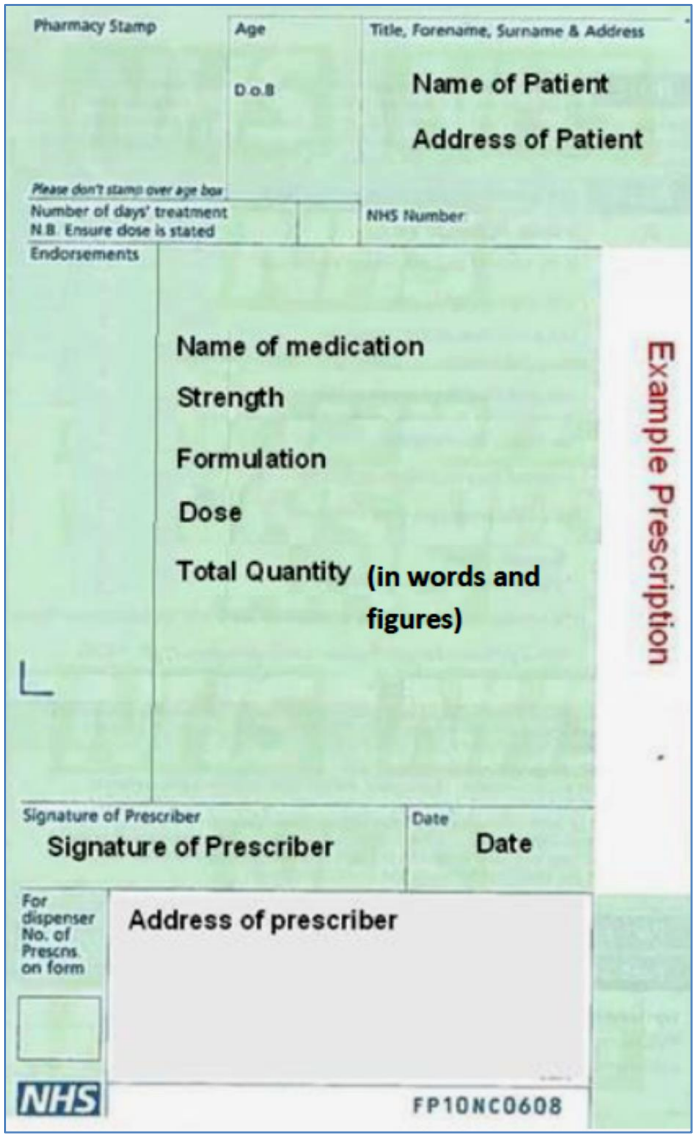
Prescription requirements for controlled drugs used at the end of life

It may help family and friends to obtain end of life medications if each item is prescribed on separate prescription forms. This will allow the items to be dispensed from several pharmacies if necessary.



Name of medication

It is good practice to use the full name e.g. morphine sulphate.

Strength

The strength of each item **MUST** be stated. To avoid ambiguity, where a prescription requests multiple strengths of a medicine, each strength should be prescribed separately.

Formulation

Abbreviations are acceptable e.g. amps. The size of the ampoule **MUST** also be stated. Most GP systems include this in the strength of the medicine e.g. **Morphine sulfate** 10mg/1ml ampoule.

Dose

The dose **MUST** be clear and unambiguous – see table below for examples of what is and is not allowed.

Total Quantity

The total quantity **MUST** be written in both words and figures expressed as the number of dosage units e.g. Ten (10) ampoules OR 2 packs of 5 ampoules (two packs of five ampoules).

Doses that are legally acceptable	Doses that are NOT legally acceptable
One as directed	As directed
One PRN	PRN
Three ampoules to be given as directed	When required
2.5 – 5mg SC PRN	As per Authorisation to Administer Form
5-20mg over 24 hours via syringe driver	Via syringe driver as directed

Example of an acceptable prescription
Morphine Sulphate 10mg/1ml Solution for Injection Ampoules
2.5-5mg S/C as required or via syringe driver as indicated on authorisation to administer form
Ten (10) Ampoules

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The following Pharmacies have been commissioned to stock palliative care medications in the Halton Borough. The range and quantity of drugs has been agreed between NHS Halton CCG and Halton Haven Hospice Palliative Care Team and Bridgewater Community Healthcare NHS Foundation Trust. Other Pharmacies may also carry some of these drugs but not necessarily the full selection.

The Pharmacy should be contacted to confirm stock availability before an individual travels to the Pharmacy.

Runcorn	
Asda Pharmacy * West La, Runcorn WA7 2PY 01928 703210 ***100 hour pharmacy**	Sunday 10:30am–4:30pm Monday 8am–11pm Tuesday 7am–11pm Wednesday 7am–11pm Thursday 7am–11pm Friday 7am–11pm Saturday 7am–10pm
Peak Pharmacy 53 Church St, Runcorn WA7 1LQ 01928 572470	Sunday Closed Monday 9am - 5.30pm Tuesday 9am - 5.30pm Wednesday 9am - 5.30pm Thursday 9am - 5.30pm Friday 9am - 5.30pm Saturday 9am - 1pm

Widnes	
Asda Pharmacy * Widnes Road, Widnes WA8 6AH 0151 422 5900 ***100 hour pharmacy**	Sunday 10am–4pm Monday 8am–11pm Tuesday 7am–11pm Wednesday 7am–11pm Thursday 7am–11pm Friday 7am–11pm Saturday 7am–10pm
Widnes Late Night Pharmacy* Beaconsfield Primary Care Centre Bevan Way (off Peelhouse Lane), Widnes WA8 6TE 0151 420 0919 ***100 hour pharmacy**	Sunday 10am–8pm Monday 8am–11pm Tuesday 8am–11pm Wednesday 8am–11pm Thursday 8am–11pm Friday 8am–11pm Saturday 8am–11pm

*** **Please note opening hours may differ on Bank Holidays.** ***

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Palliative Care Formulary Stocked by Palliative Care Pharmacies

Prescribers should take care to select the correct medication as there are a variety of strengths, dose forms and pack sizes available.

Selecting items from the formulary and prescribing each item on a separate form may help families and friends to obtain the prescribed medication more easily.

Drug name	Formulation	Strength
Alfentanil	Injection	500microgram/ml injection (2ml ampoules)
Cyclizine	Injection	50mg/ml (1ml ampoule)
Dexamethasone	Injection	3.8mg/ml (1ml ampoule ASPEN)
Diamorphine HCl	Injection	5mg
Diamorphine HCl	Injection	10mg
Diamorphine HCl	Injection	30mg
Diamorphine HCl	Injection	100mg
Glycopyrronium bromide	Injection	200micrograms/ml (1ml ampoule)
Glycopyrronium bromide	Injection	200micrograms (3ml ampoule)
Haloperidol	Injection	5mg/ml (1ml ampoule)
Hyoscine butylbromide	Injection	20mg/ml (1ml ampoule)
Hyoscine hydrobromide	Injection	400mcg/ml injection (1ml ampoule)
Levomepromazine	Injection	25mg/ml (1ml ampoule)
Midazolam	Injection	5mg/ml (2ml ampoule)
Morphine sulphate	Injection	10mg/ml (1ml ampoule)
Morphine sulphate	Injection	30mg/ml (1ml ampoule)
Oxycodone hydrochloride	Injection	10mg/ml (1ml ampoule)
Oxycodone hydrochloride	Injection	10mg/ml (2ml ampoule)
Sodium chloride	Injection	0.9% w/v (10ml ampoule)
Sodium chloride	Injection	0.9% w/v (100 ml)
Water for injection	Injection	2ml
Water for injection	Injection	5ml
Water for injection	Injection	10ml