



**Countess of  
Chester Hospital**  
NHS Foundation Trust

# Key priorities and guidance for care in the last few days and hours of life

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Hospital Version (5<sup>th</sup> edition)

Produced in partnership with Countess of Chester NHS Foundation Trust, Cheshire and Wirral Partnership, the Hospice of the Good Shepherd and West Cheshire Clinical Commissioning Group

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# Introduction

The purpose of this document is to provide guidance to facilitate the delivery of good quality holistic end of life care for those people who are identified as being in the last days and hours of their life.

There may be uncertainty in identifying when someone is dying. Illness can be unpredictable and changes may occur suddenly.

This document does not provide detailed instruction or a list of steps to be taken. Each person is an individual with their own particular priorities, concerns and preferences. This document should inform the reasoning which is necessary to provide individualised person-centred care.

This document aims to guide health and other care professionals supporting people who are recognised as being in the last days and hours of their life and their families. It highlights key priorities which are applicable in all care settings and should be used in conjunction with other local policies, the 5 key priorities advocated in `One chance to get it right` (2014) <sup>1</sup> and NICE guidance `Care of dying adults in the last days of life` (2015).<sup>2</sup>

Staff can be confident that they are providing good individualised care for people who are in the last days and hours of life by:

- Applying the key priorities
- Ensuring their care takes into account the uncertainty involved in recognising that someone is dying
- Understanding the importance of sensitive and clear communication with people who are recognised as possibly being in the last days and hours of life, their families and those who are important to them.
- Understanding the role of food and drink in the dying phase
- Following locally recognised good practice guidance about end of life care
- Directing people, families and those identified as being important to them to relevant information according to their assessed needs.

The document is also available to members of the public.

## 5 Key Priorities<sup>1</sup>

The key priorities highlight essential aspects of care for teams to address when caring for people in the last days and hours of life. Applying these principles will support staff in caring for dying people and those close to them.

When it is thought possible that a person may die within the next few days or hours, the priorities for care are:<sup>1</sup>

### **1. Recognise**

The possibility that a person may be dying is recognised and communicated, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.

### **2. Communicate**

Sensitive communication takes place between staff and the dying person, and those identified as important to them.

### **3. Involve**

The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.

### **4. Support**

The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.

### **5. Plan and do**

An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support is agreed, coordinated and delivered with compassion.

The priorities of care reinforce that the focus for care in the last few days and hours of life must be the person who is dying. The priorities are set out in sequential order but are all equally important to achieving good care in the last days and hours of life and there is significant overlap between them. Each supports the primary principle that individual care must be provided according to the needs and wishes of the dying person.

# Clinical Guidelines

These guidelines aim to facilitate clinical decision-making and good practice in person-centred care for people who are deteriorating and likely to be in the last few days or hours of life. It is recognised that there can be uncertainty in identifying when a person is dying and reversible causes for the person's deterioration should be excluded or treated where appropriate.

For example:

- Dehydration
- Hypercalcaemia
- Opioid toxicity
- Sepsis
- Withdrawal of steroids
- Delirium
- Acute kidney injury

Changes that may indicate that a person is entering the last few weeks or days of life may include:

- Signs such as agitation, Cheyne-Stokes breathing, deterioration in level of consciousness, mottled skin, noisy respiratory secretions and progressive weight loss
- Symptoms such as increasing fatigue and loss of appetite
- Functional observations such as changes in communication, deteriorating mobility or performance status or social withdrawal

Be aware that improvement in signs and symptoms or functional observations could indicate that a person may be stabilizing or recovering.<sup>2</sup>

The clinical team must fully assess the physical, psychological, spiritual and social needs of the person.

Where the doctor (senior clinician with overall responsibility) has identified that a person is in the last few days or hours of life they must discuss and agree a plan of care with the person (where possible) their family and those identified as important. Ideally this should be done in-hours and by the team who know the person best.

The agreed plan of care should clarify and document the following:

- Significant decisions about a person's care, including recognising dying, which should be made on a shared decision-making basis.
- Recognition of dying and the rationale for this
- The person's understanding and holistic care preferences
- The understanding of the family and those identified as being important, of the current situation
- Proposed plan of care including discussion about:
  - Do not attempt cardio pulmonary resuscitation (DNA-CPR) status
  - Deactivation of implantable cardioverter-defibrillator (ICD) according to local policy, if the person has one in place.
  - The risks and benefits of food and drink.
  - Discontinuation of routine nursing observations and interventions not thought to be clinically appropriate.
  - Planned nursing interventions should include:
    - Supporting the person to take food and drink as long as they are able and want to.
    - Comfort care including:
      - Pressure area care and repositioning for comfort
      - Eye care
      - Mouth care
      - Bowel and bladder care
      - Assessment of symptoms
- All medication should be reviewed and non-essential medication(s) should be discontinued with essential medication(s) being continued by the appropriate parental route.
- Use an individualised approach to prescribing anticipatory medicines for people who are likely to need symptom control in the last days of life. Specify the indications for use and the dosage of any medicine prescribed.
- Assess what medicines the person might need to manage symptoms likely to occur during their last days of life (such as agitation, anxiety, breathlessness, nausea and vomiting, noisy respiratory secretions and pain). Discuss any prescribing needs with the dying person, those important to them and the multiprofessional team.<sup>2</sup>
- When deciding which anticipatory medicines to offer take into account:
  - The likelihood of specific symptoms occurring
  - The benefits and harms of prescribing or administering medicines
  - The benefits and harms of not prescribing or administering medicines

- The possible risk of the person suddenly deteriorating (for example, catastrophic haemorrhage or seizures) for which urgent symptom control may be needed.
- The place of care and the time it may take to obtain medicines<sup>7</sup>
- Seek specialist palliative care advice if needed eg for advice on anticonvulsants, steroids, insulin and other complex symptom management.

## **Decision- Making and Capacity**

The focus of care in the last few days and hours of life must be the person who is dying and their needs and wishes.

For some people who are entering the last days of life, mental capacity to understand and engage in shared decision-making may be limited. This may be temporary or fluctuating. This guidance should be used in conjunction with the Mental Capacity Act (2005)<sup>3</sup>.

If a person lacks capacity and there is a valid and applicable Advance Decision to Refuse Treatment (ADRT) then this must be abided by as it is legally binding. If the person has appointed a Lasting Power of Attorney (LPA) who has been registered for Health and Welfare, then the LPA can make decisions on the person's behalf.

If it is established that a person lacks capacity at the relevant time to make the relevant decision then a decision must be taken in their best interests in accordance with the Mental Capacity Act (2005).<sup>3</sup> The person making the decision must, if it is practicable and appropriate to do so, consult:

- Anybody named by the person as someone to be consulted on either the decision in question or similar issues;
- Anyone engaged in caring for the person, close relatives, friends or others who take an interest in the person's welfare;
- Any holder of a lasting power of attorney or enduring power of attorney;
- Any deputy appointed by the court to make decisions for the person.

Also consider whether they have previously expressed preferences pertaining to their end of life care.

Further guidance on making a best interests decision is provided in the Mental Capacity Act Code of Practice<sup>4</sup> and in local organisational policies. The Coroner considers the death of any person with an authorised Deprivation of Liberty Safeguard (DoLS) an inquest case due to the fact that a DoLS is essentially a state detention. Refer to local organisational policies regarding DoLS and referral to the Coroner.

For any dying person who is assessed to lack capacity and has no-one else to support them other than members of the healthcare team, consider consulting with the Independent Mental Capacity Advocate (IMCA) service.

## **Food and drink<sup>1,2,5,6,7</sup>**

It is normal for a person who is dying not to feel like eating and drinking and it is important that this is explained to the person, their family and those identified as important.<sup>1</sup>

It is essential to consider how the person currently receives food and fluids (oral, intravenous, subcutaneous, nasogastric, PEG) and ascertain if this is adequate and appropriate.

People who are able to eat and/or drink should be helped and supported to do so if they wish, unless they choose not to. If a dying person makes an informed choice to eat or drink, even if they are deemed to be at risk of aspiration, this must be respected.<sup>1,2</sup> and they should be monitored for signs of aspiration/choking or distress.

When considering clinically assisted hydration for a dying person, use an individualised approach and take into account:

- Whether they have expressed a preference for or against clinically assisted hydration, or have any cultural, spiritual or religious beliefs that might affect this documented in an advance statement or advance decision to refuse treatment (ADRT)
- Their level of consciousness
- Any swallowing difficulties
- Their level of thirst



- The risk of pulmonary oedema
- Whether even temporary recovery is possible.

Giving clinically assisted hydration may relieve distressing symptoms or signs related to dehydration but it may also cause pain, discomfort or swelling at the infusion site. Health care professionals and people important to the dying person may believe that providing clinically assisted hydration will prolong dying or that `withholding` it will hasten death, but there is no evidence for this. <sup>1,2</sup>

Consider a therapeutic trial of clinically assisted hydration if the person has distressing symptoms or signs that could be associated with dehydration such as thirst or delirium, and oral hydration is inadequate.

For people being started on clinically assisted hydration:

- Monitor at least every 12 hours for changes in the symptoms or signs of dehydration, and for any evidence of benefit or harm
- Continue with clinically assisted hydration if there are signs of clinical benefit
- Reduce or stop clinically assisted hydration if there are signs of possible harm to the dying person, such as fluid overload, or if they no longer want it.

Decisions about the use and/or discontinuation of clinically-assisted hydration and nutrition (i.e. intravenous, subcutaneous, nasogastric, PEG) must be based on consideration of the needs and circumstances of the particular individual person and must be in line with the General Medical Council (GMC) 2010 guidance *Treatment and care towards the end of life: Good practice in decision making*.<sup>7</sup>

The rationale for decisions and/or changes should be promptly communicated and carefully explained to family and those identified as important and the risk and benefits of clinically- assisted hydration and nutrition discussed with the person (where possible), family and those identified as important to the person.

Decisions surrounding use of clinically-assisted hydration and nutrition should be discussed with the multi professional team, the person, family and those identified as important in accordance with the Mental Capacity Act (2005).

There is evidence to suggest that clinically assisted hydration may aggravate oedema, ascites and pleural effusions in people with advanced cancer but may reduce myoclonus and sedation at the end of life.

There is no robust evidence to suggest that clinically assisted hydration causes or aggravates respiratory tract secretions in people who are dying.

Decisions to start or continue clinically- assisted hydration in the last days and hours of life must always be communicated with an acknowledgement that it will be reviewed and discontinued if it causes problems for the dying person.

Regular mouth care remains essential during the last days and hours of life and health and social care staff must pay attention to the dying person's mouth care and other personal needs to maintain their comfort and dignity. Encourage those important to the dying person to help with mouth and lip care or giving drinks if they wish to. Provide any necessary aids and give them advice on giving drinks safely.

## **Spiritual care <sup>2</sup>**

It is important that spiritual and religious needs are regularly assessed and reviewed, as these are individual and may change. Support from the chaplaincy team should be offered.

Spiritual care is that care which recognises and responds to the needs of the human spirit when faced with trauma, ill health or sadness and can include the need for meaning, for self-worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener. Spiritual care begins with encouraging human contact in compassionate relationship, and moves in whatever direction need requires.<sup>8</sup>

When specialist spiritual/religious support is identified as required, health and care staff must ensure that the dying person, and those important to them, have ready access to information about the available chaplaincy and/or spiritual care provision.

Chaplains must have information about local faith leaders to enable, where requested by the person, referral to church or faith community leaders.

Staff must find out from the dying person, their family and those important to them, the details of any cultural or religious-specific requirements, including what constitutes respectful treatment of the body after death.<sup>1</sup>

## Symptom control in the last days and hours of life

### **General principles**

All medications, including anticipatory medicines, must be targeted at specific symptoms, have a clinical rationale for the starting dose, be regularly reviewed and adjusted as needed for effect.

When involving the dying person and those important to them in making decisions about symptom control in the last days of life:

- Use the dying person's individualized care plan to help decide which medicines are clinically appropriate.
- Discuss the benefits and harms of any medicines offered.

When considering medicines for symptom control, take into account:

- the likely cause of the symptom
- the dying person's preferences alongside the benefits and harms of the medicine
- any individual or cultural views that might affect their choice
- any other medicines being taken to manage symptoms
- any risks of the medicine that could affect prescribing decisions, for example prescribing cyclizine to manage nausea and vomiting may exacerbate heart failure.

Decide on the most effective route for administering medicines in the last days of life tailored to the dying person's condition, their ability to swallow safely and their preferences.

Consider prescribing different routes of administering medicine if the dying person is unable to take or tolerate oral medicines. Avoid giving intramuscular injections and give either subcutaneous or intravenous injections.

It is important to explain to the dying person, their family and those identified as important to them, the reason for any intervention, including the use of a continuous subcutaneous infusion (usually via a syringe driver). Other than in exceptional circumstances, this should be done before it is commenced.

It should be discussed with the dying person the likely side-effects of specific interventions, especially those that may make them sleepy. This will enable them to make informed decisions, and should also be explained to those important to the dying person if the person wishes.

Symptoms commonly experienced by people in the last hours and days of life are:-

- Pain
- Breathlessness
- Excessive respiratory tract secretions
- Restlessness / agitation
- Nausea and vomiting

It is important that medications to control the above symptoms are prescribed in anticipation of symptoms occurring.

'As required' doses should be prescribed with a clearly stated maximum dose and frequency where applicable. For people starting treatment who have not previously been given medicines for symptom management, start with the lowest effective dose and titrate as clinically indicated. <sup>2</sup>

It is important that established medications for currently controlled symptoms are converted to the appropriate parenteral equivalent as required.

The subcutaneous route is recommended for parenteral use in last days or hours of life and if two or more 'as required' doses are needed over 24 hours, a continuous subcutaneous infusion (CSCI) should be considered if not already in place or the dose adjusted in an established CSCI.

## Guidelines

Refer also to prescribing algorithms, available electronically at

<http://intranet.xcoch.nhs.uk/clinical-services/palliative-and-end-of-life-care/dying.aspx>

## Pain

Consider non-pharmacological management of pain in a person in the last days of life.

Not all people in the last days of life experience pain. If pain is identified manage it promptly and effectively and treat any reversible causes of pain such as urinary retention.<sup>7</sup>

People unable to take regular oral opioids should have their analgesia converted to an equivalent dose of opioid administered by continuous subcutaneous infusion (CSCI) this will usually be via a syringe driver.

Morphine sulphate is the parenteral opioid of choice in the last days or hours of life, unless the person is already established on an alternative opioid for a specific reason.

If the person is opiate naïve morphine sulphate injection 2.5mg to 5mg subcutaneously 2 to 4 hourly is an appropriate starting dose.

Morphine sulphate should be used cautiously in people with renal failure. Contact the specialist palliative care team for advice.

### **Commencing morphine sulphate as a CSCI in people receiving oral morphine sulphate:**

#### **To calculate total 24 hour subcutaneous dose required:**

$$\frac{\text{Total 24 hour oral morphine sulphate}}{2} = \text{24 hour morphine sulphate injection in syringe driver (CSCI)}$$

#### **Breakthrough (as required) dose:**

$$\frac{\text{24 hour morphine sulphate injection (CSCI)}}{6} = \text{morphine sulphate injection subcutaneously 2 to 4 hourly as required}$$

For people whose pain is controlled with transdermal opioids the patch should be continued and not removed in the last days or hours of life. If an increase in pain relief is needed additional analgesia can be given.

For people whose pain is managed with a transdermal patch, appropriate 'as required' doses of immediate release morphine sulphate should be prescribed as a subcutaneous injection.

If two or more of these doses are required over 24 hours a CSCI should be considered **in addition to the patch**

Contact the specialist palliative care team for further advice on pain management for people whose pain is poorly controlled in the last days and hours of life or for advice on alternative opioids or if they are experiencing undesirable side effects.

## **Breathlessness**

Identify and treat reversible causes of breathlessness in the dying person, for example pulmonary oedema or pleural effusion.

Non- pharmacological options should be considered these include

- Reassurance and explanation
- Use of a fan or cool air across the face
- Adequate positioning of the patient to aid breathing.

Do not routinely start oxygen to manage breathlessness. Only offer oxygen therapy to people known or clinically suspected to have symptomatic hypoxaemia.

People who are breathless and already established on a long acting opioid eg modified release preparations may benefit from an 'as required' dose of immediate release opioids. This should be fully assessed according to the person's preference and response to medication.

Benzodiazepines can be useful in the management of breathlessness. If the person is still able to take oral medication consider lorazepam 500 micrograms to 1mg sublingually. If not an alternative injection of midazolam 2.5mg subcutaneously could be considered.

**Refer to algorithms \***

If the person finds the administration of oxygen helpful to relieve their breathlessness it can be continued. Nasal prongs may be better tolerated than a mask.

## Respiratory tract secretions

It is important to talk to families and those identified as being important, giving explanation and reassurance, as this symptom may cause considerable distress to them.

Non- pharmacological measures are an important part of the management and may simply include a change of position.

Consider a trial of medicine to treat noisy respiratory secretions if they cause distress to the dying person. **Refer to algorithms** \*

When giving medicine for noisy respiratory secretions:

- Monitor for improvements, preferably every 4 hours, but at least every 12 hours
- Monitor regularly for side-effects, particularly delirium, agitation or excessive sedation when using hyoscine hydrobromide.
- Treat side-effects, such as dry mouth, delirium or sedation.

Consider changing or stopping medicines if noisy respiratory secretions continue and are still causing distress after 12hours (medicines may take up to 12hours to become effective).

Suction should be avoided, as this maybe distressing to the person and only used as a last resort.

Fluid overload, recent aspiration and respiratory infection can increase the incidence of respiratory tract secretions.

## Agitation, restlessness and delirium

Explore the possible causes of anxiety or delirium, with or without agitation, with the dying person and those important to them. Be aware that agitation in isolation is sometimes associated with other unrelieved symptoms or bodily needs, for example, unrelieved pain or a full bladder or rectum.

Consider non-pharmacological management of agitation, anxiety and delirium in a person in the last days of life.<sup>2</sup>

Possible reversible causes of the agitation / restlessness should be sought and managed appropriately. Examples include:

- Urinary retention
- Opioid toxicity
- Nicotine withdrawal
- Constipation
- Noise

Midazolam 2.5mg 'as required' should be prescribed and administered subcutaneously for anxiety and agitation. **See algorithms\***

If a reversible cause for the agitation or restlessness is found this should be addressed if appropriate and the person assessed regularly for any further agitation/restlessness and 'as required' doses of midazolam administered as needed. It may be necessary to commence a syringe pump.

If terminal agitation is a problem alternative medication such as levomepromazine can be used and advice sought from the specialist palliative care team.

Haloperidol 2.5mg subcutaneously may be useful for people who are hallucinating.

Consider a nicotine replacement patch in heavy smokers.

Opioid analgesics should not be used to sedate people.

Acknowledge spiritual distress amongst the person, family and those identified as being important to them and access spiritual support appropriate to their need.

## **Nausea and vomiting**

Assess for likely causes of nausea and vomiting in the dying person. These may include:

- Certain medicines that may cause or contribute to nausea and vomiting
- Recent chemotherapy or radiotherapy
- Psychological causes
- Biochemical causes such as hypercalcaemia
- Raised intracranial pressure
- Gastrointestinal motility disorder



- Ileus or bowel obstruction

Consider non-pharmacological methods for treating nausea and vomiting in a person in the last days of life.

For people whose nausea and vomiting is controlled with an oral anti-emetic, this can be converted to a CSCI.

For people who are opioid naïve consider the prescribing of an anti-emetic orally or subcutaneously according to their needs.

For those people who have had symptoms controlled with oral opioids but have not required regular anti-emetics there is no need to routinely prescribe regular anti-emetics, however, 'as required' prescribing should be considered for potential causes of nausea other than opioids.

Cyclizine may exacerbate symptoms of heart failure and should be avoided in these people.<sup>9</sup> Consider the use of haloperidol or levomepromazine, but be aware that this may cause unpredictable sedation which should be discussed with the patient and those important to them.<sup>2,10</sup>

## **Acute terminal events**

Some dying people occasionally develop acute distress due to:

- Bleeding
- Acute pain
- Acute respiratory distress

People should be assessed for other causes of distress specific to their illness.

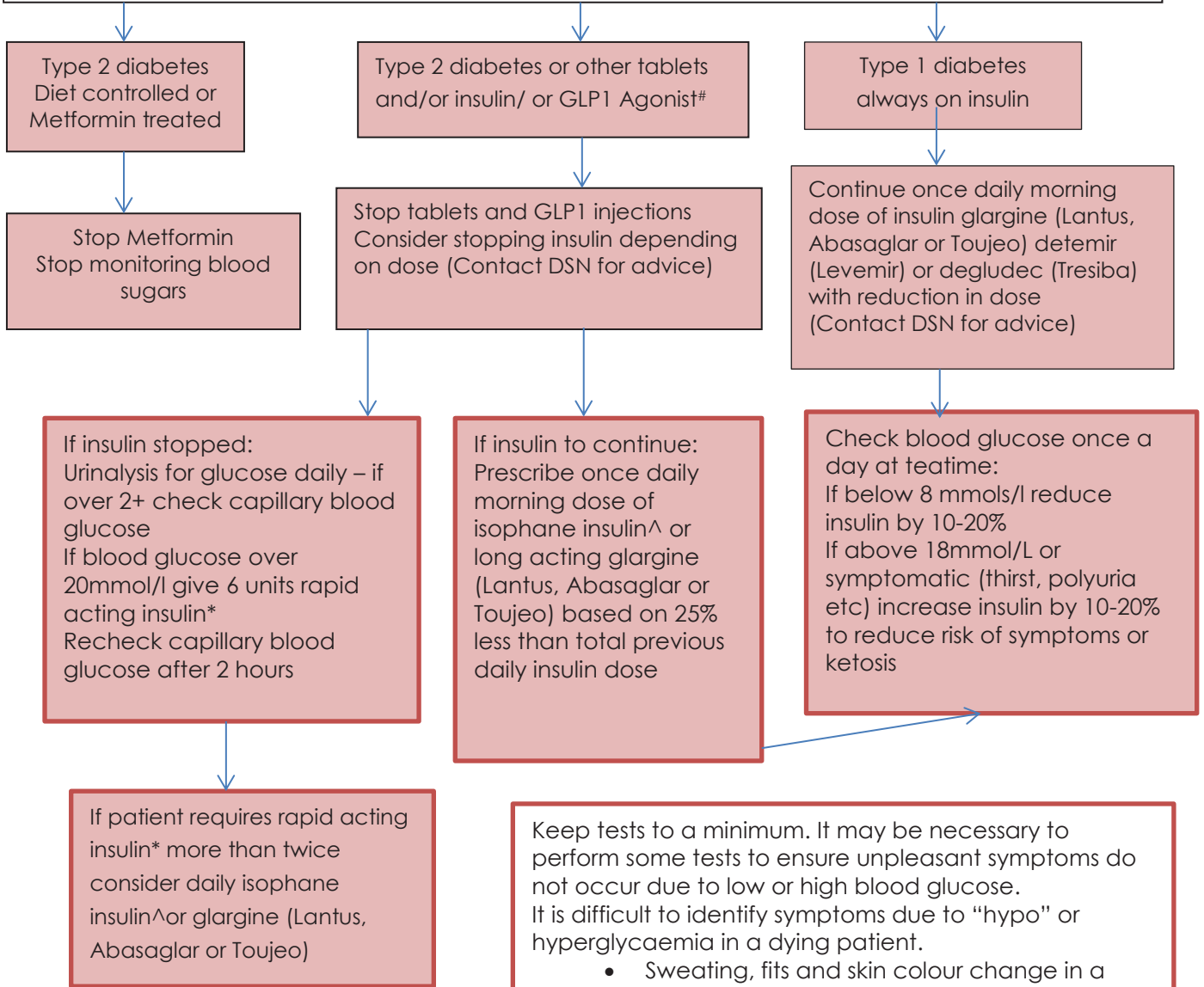
Prescribe anticipatory medication in advance if the person is at risk and discuss with family and those identified as being important to them. Agree an anticipatory care plan with the person, if possible, the family and those identified as being important to them.

Consider the anticipatory prescribing of intra-nasal midazolam.<sup>10</sup>

# Diabetes management in the last hours and days of life

Aim for Blood Glucose reading of 8 – 18mmol/L

Discuss changing the approach to diabetes management with patient and/or family if not already explored. If the patient remains on insulin ensure the Diabetes Specialist Nurses (DNSs) are involved and agree monitoring strategy.



**Key**  
 # Byetta (Exenatide)/Victoza,  
 (Liraglutide), Lyxumia (Lixisenatide)  
 \*Humalog/Novorapid/Apidra  
 ^Humulin I/Insulatard/Insuman Basal

Keep tests to a minimum. It may be necessary to perform some tests to ensure unpleasant symptoms do not occur due to low or high blood glucose. It is difficult to identify symptoms due to "hypo" or hyperglycaemia in a dying patient.

- Sweating, fits and skin colour change in a drowsy or unconscious person may be due to hypoglycaemia

If symptoms are observed it could be due to abnormal blood glucose levels  
 Test urine or blood for glucose if the patient is symptomatic  
 Observe for symptoms in previously insulin treated patient when insulin has been discontinued  
 If PEG feeding is to continue, see specialist advice from DNSs/ Palliative Care Team.  
 It is worth remembering that if steroids are continued in the dying phase they can affect blood glucose levels

The Hospital Specialist Palliative Care Team are available Mon-Friday 9am-5pm on 01244 366086 or bleep 2689  
 The Diabetic Specialist Nurses are available Mon-Friday 9am – 5pm on ext 01244 363061 or bleep 2796

# PRESCRIBING GUIDELINES FOR SYMPTOM MANAGEMENT IN THE LAST FEW DAYS AND HOURS OF LIFE

Palliative care team, Countess of Chester NHS Hospital 01244 366086 (9am to 5pm)

24/7 PALLIATIVE CARE ADVICE LINE FOR HEALTH PROFESSIONALS based at Hospice of the Good Shepherd,  
Chester: 01244 852520

Acknowledgement to Halton, St Helens and Knowsley palliative care teams for permission to adapt their guidelines

## **Resources**

Cheshire and Merseyside Palliative & End of Life Care Strategic Clinical Network Standards and Guidelines

`Symptom control medication & the dying person (Oct 2015);

North West Coast Strategic Clinical Networks `Clinical Practice Summary for Palliative Care Symptoms` (March 2017)

Palliative Care Formulary 6th Ed (2018) Palliativedrugs.com Ltd

## PRESCRIBING GUIDELINES FOR SYMPTOM MANAGEMENT IN THE LAST FEW DAYS AND HOURS OF LIFE

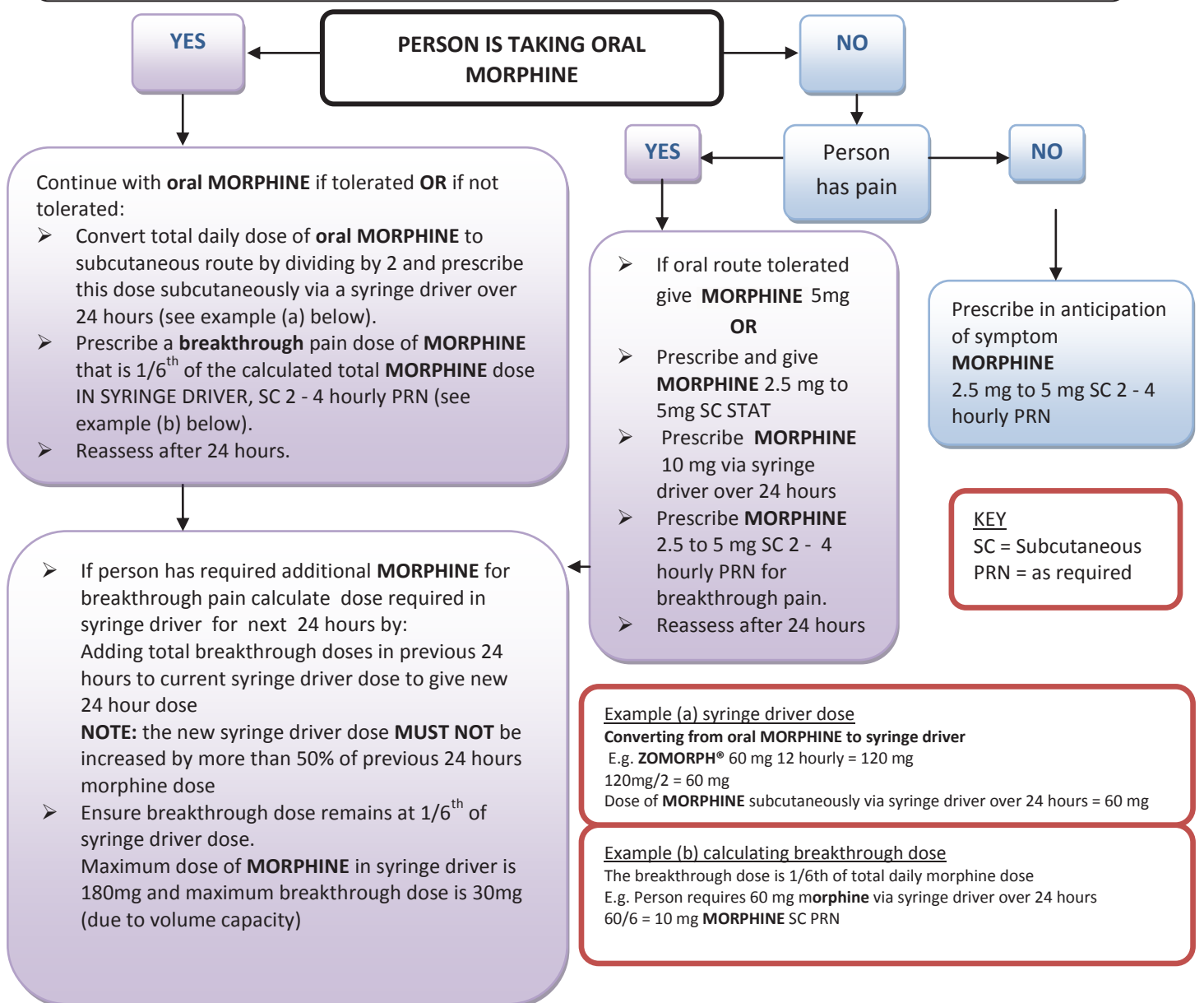
### PAIN MANAGEMENT

Person established taking 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 person. 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 FOR ADVICE IF:

- The person has moderate to severe renal failure (ie if eGFR < 30mls/minute).
- The person has new severe pain or pain that has persisted after 24 hours on a syringe driver.



## PRESCRIBING GUIDELINES FOR SYMPTOM MANAGEMENT IN THE LAST FEW DAYS AND HOURS OF LIFE

### PAIN MANAGEMENT

#### Persons established using 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 person. 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 person has **severe** renal dysfunction and requires additional pain relief seek advice on prescribing from the palliative care team.

#### FENTANYL ESTABLISHED

**DO NOT** remove **FENTANYL** patch.  
Continue and re-apply every 72 hours.

PAIN PRESENT

PAIN CONTROLLED  
Prescribe opioid for breakthrough pain as needed.  
See table below.

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

#### OBTAIN SPECIALIST PALLIATIVE CARE ADVICE REGARDING CALCULATING SUBSEQUENT PRN DOSE OF OPIOID S/C ONCE OPIOID IS REQUIRED IN SYRINGE DRIVER.

Fentanyl patch strength	Up to 4 hourly <b>MORPHINE</b> SC PRN	Up to 4 hourly <b>OXYCODONE</b> SC PRN
12 micrograms per hour	2.5 mg	1.25mg to 2.5mg
25 micrograms per hour	5 mg	2.5 mg
50 micrograms per hour	10 mg	5 mg
75 micrograms per hour	20 mg	10 mg

When calculated syringe driver doses of morphine exceed 180mg; or morphine breakthrough doses exceed 30mg, diamorphine will need to be considered. Contact specialist palliative care team for advice.

## PRESCRIBING GUIDELINES FOR SYMPTOM MANAGEMENT IN THE LAST FEW DAYS AND HOURS OF LIFE

### PAIN MANAGEMENT

For people established taking 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 person. 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.
- IN THE DYING PHASE USE 3:2 AS BELOW

CONVERT ORAL OXYCODONE TO SUBCUTANEOUS ROUTE AS BELOW

- **CALCULATE DOSE REQUIRED OVER 24 HOURS IN SYRINGE DRIVER:  
SYRINGE DRIVER DOSE =  $\frac{2}{3}^{\text{RD}}$  OF ORAL DAILY DOSE.**

E.g. **OXYCONTIN**® 45 mg 12 hourly = 90 mg in 24 hours  
 $\frac{2}{3}^{\text{rd}}$  of 90 mg = 60 mg  
 Dose required in syringe driver = 60 mg

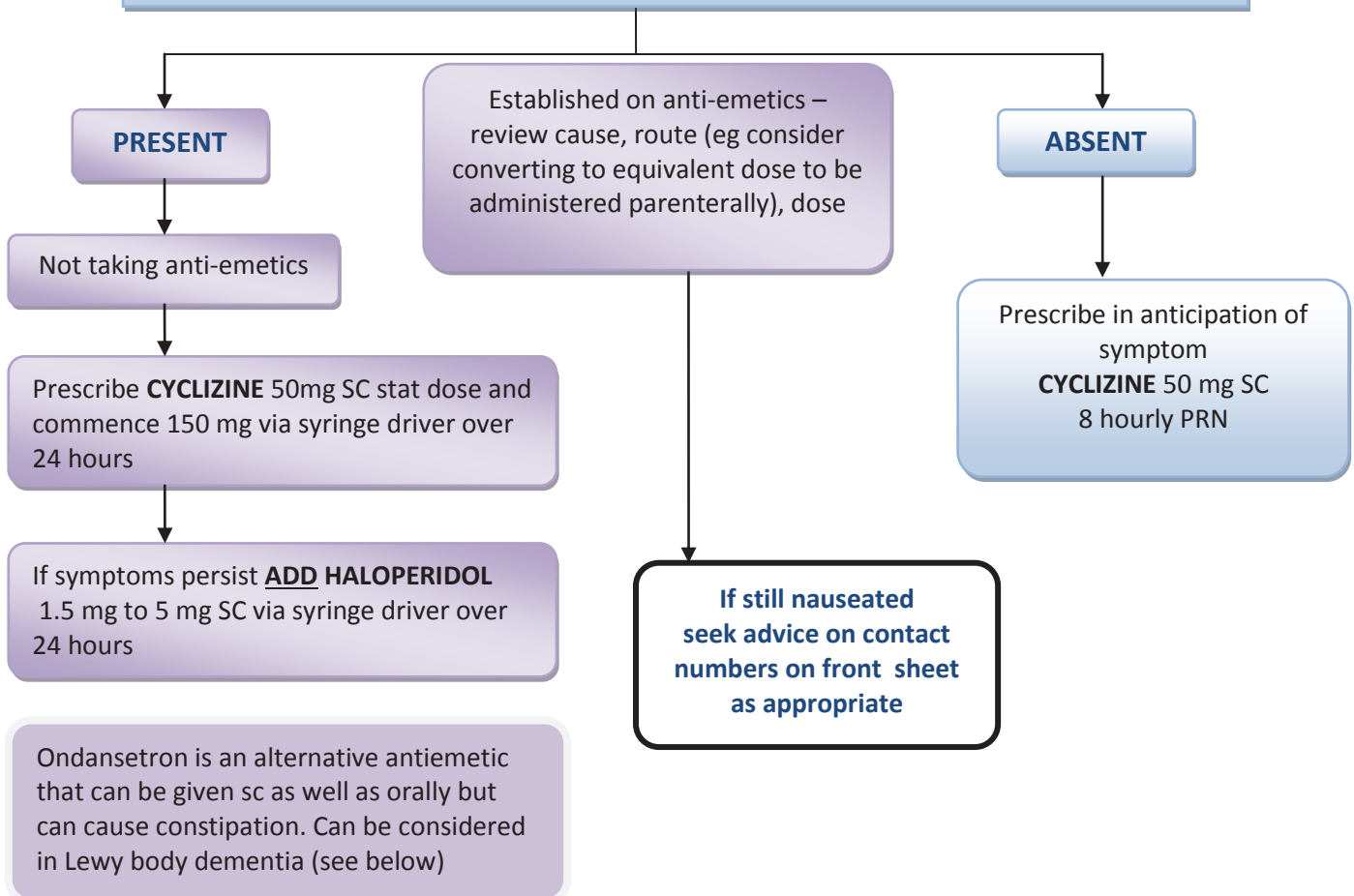
- **CALCULATE DOSE OF OXYCODONE REQUIRED FOR RELIEF OF  
BREAKTHROUGH PAIN.  
BREAKTHROUGH DOSE =  $\frac{1}{6}^{\text{TH}}$  DOSE IN SYRINGE DRIVER.**

E.g. **OXYCODONE** 60 mg/24 hours in syringe driver = 10 mg **OXYCODONE**  
 SC 2 - 4 hourly PRN

- **RE-ASSESS AFTER 24HRS** – if person has required breakthrough analgesia calculate total amount given in previous 24 hours and increase dose in syringe driver by up to **50%** of this amount.
- **ENSURE THAT BREAKTHROUGH DOSE REMAINS  $\frac{1}{6}^{\text{th}}$  OF DOSE IN SYRINGE DRIVER**

## PRESCRIBING GUIDELINES FOR SYMPTOM MANAGEMENT IN THE LAST FEW DAYS AND HOURS OF LIFE

### NAUSEA & VOMITING – for people without heart failure



**HEART FAILURE:** (reference - Cheshire and Merseyside Clinical Network: Guidelines for symptom control for adults with end-stage heart failure January 2014)

**CYCLIZINE IS NOT RECOMMENDED IN PEOPLE WITH HEART FAILURE** (unless very short prognosis)

**METOCLOPRAMIDE** 10mg SC PRN plus initial dose of 30mg via syringe driver over 24 hours is first line (contra-indicated in gastro-intestinal obstruction; avoid or use with extreme caution in abdominal colic)

If chemical causes of nausea and vomiting e.g. renal failure or medication

**HALOPERIDOL** 0.5mg to 3mg SC PRN plus 1.5mg to 5mg via syringe driver over 24 hours, maximum 10mg / 24hours OR **LEVOMEPRMAZINE** 6.25mg SC 8 hourly PRN plus 6.25 mg to 12.5mg to 25 mg via a syringe driver over 24 hrs

#### **LEWY BODY DEMENTIA**

For people with Lewy Body dementia **AVOID** haloperidol, levomepromazine and metoclopramide. Consider **ONDANSETRON** at dose of 4mg po/sc or in syringe driver at dose of 8 – 16mg over 24hours.

## PRESCRIBING GUIDELINES FOR SYMPTOM MANAGEMENT IN THE LAST FEW DAYS AND HOURS OF LIFE

### 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)

**PRESENT**

Common reversible causes of agitation include **urinary retention, constipation, nicotine withdrawal, opioid toxicity & environmental factors**. All should be excluded.

- Prescribe **MIDAZOLAM** 2.5 mg to 5 mg SC PRN until syringe driver commenced. If 2.5 mg ineffective after 30 minutes, give a further 5 mg (total 7.5 mg in 1 hour). If person remains agitated seek medical review and contact Specialist Palliative Care Team for advice.
- If agitation likely to persist commence **MIDAZOLAM** 10 mg to 20 mg SC via syringe driver over 24 hours.
- In addition prescribe **MIDAZOLAM** 2.5 mg to 5 mg SC 2 - 4 hourly PRN.
- If eGFR < 30ml/min give reduced dose of **MIDAZOLAM** eg 1 – 2.5mg SC 2 – 4 hourly PRN
- If delirious consider **HALOPERIDOL** 0.5mg SC 2 - 4hourly PRN (monitor for extrapyramidal side effects. If needed in a syringe driver dose 2.5 – 8mg over 24hours)

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 1/6<sup>th</sup> of syringe driver dose.
- If MIDAZOLAM 30 mg in syringe driver is reached and symptoms are not controlled, please seek advice.**

**ABSENT**

Prescribe in anticipation of symptom  
**MIDAZOLAM** 2.5 mg to 5 mg SC up to 2 - 4 hourly PRN.  
**Maximum 30 mg in 24 hours**



## PRESCRIBING GUIDELINES FOR SYMPTOM MANAGEMENT IN THE LAST FEW DAYS AND HOURS OF LIFE

### RESPIRATORY TRACT SECRETIONS

Patient can't clear secretions from their upper respiratory tract properly causing secretions to move as they breath

Explanation of these symptoms to those important to the dying person and non-pharmacological measures eg repositioning patient are an important part of the management plan

It is important to start treatment as soon as symptoms occur

**PRESENT**

- **EITHER: GLYCOPYRRONIUM** 200 micrograms 6 hourly SC PRN **OR HYOSCINE HYDROBROMIDE** 400 micrograms SC PRN and
- Commence syringe driver containing **EITHER GLYCOPYRRONIUM** 600 to 1200 to 2400 micrograms over 24 hours **OR**
- **HYOSCINE HYDROBROMIDE** 1.2 to 2.4 mg over 24 hours
- These are maximum doses. There is no benefit from additional PRN doses.

Anticholinergic side effects can arise, treat with frequent mouth care.

If one anticholinergic agent does not work try switching to the other after full titration to maximum dose over 24 hours. If there is still no improvement consider stopping the medication.

If not responding seek specialist advice as required

**ABSENT**

Prescribe **GLYCOPYRRONIUM** 200 micrograms SC 4 hourly PRN (Maximum 2400 micrograms in 24 hours) **OR HYOSCINE HYDROBROMIDE** 400 micrograms SC 4 hourly PRN

Prescribing in anticipation of this common symptom may prevent delay in commencing treatment.

## PRESCRIBING GUIDELINES FOR SYMPTOM MANAGEMENT IN THE LAST FEW DAYS AND HOURS OF LIFE

### BREATHLESSNESS



YES

DISTRESSING  
BREATHLESSNESS

NO



- Prescribe **MORPHINE** 1.25 mg to 2.5 mg SC 2 - 4 hourly PRN and **MIDAZOLAM** 2.5 mg SC 2 - 4 hourly PRN
- State on medicine chart/authorisation to administer chart that indication is breathlessness
- **Or if breathlessness is constant:**
- **MORPHINE** 5 mg to 10 mg via syringe driver over 24 hours (if previously taking oral opioid for breathlessness convert previous oral opioids dose - see pain algorithm) **and** **MIDAZOLAM** 5 mg to 10 mg via syringe driver over 24 hours.
- If dying person allergic or intolerant of morphine or if eGFR <30mls/min an alternative strong opioid should be prescribed  
Eg **OXYCODONE** 1 to 3mg SC up to 2 – 4 hourly PRN

Prescribe PRN opioids & anxiolytic in anticipation of symptom:

**MORPHINE** 1.25 – 2.5mg SC 2 - 4 hourly PRN  
**and**  
**MIDAZOLAM** 2.5 mg SC 2 - 4 hourly PRN

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## Further resources

24/7 PALLIATIVE CARE ADVICE LINE FOR HEALTH PROFESSIONALS: 01244 852520  
Palliative care team, Countess of Chester NHS Hospital 01244 366086 (9am to 5pm)  
Palliative care team, CWP West 01244 340631 (9am to 5pm)  
Hospice of the Good Shepherd, Chester 01244 851091

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