COLLABORATIVE SYMPTOM CONTROL GUIDELINES
for Care of the Dying Patient in the last days of life

These guidelines are to be used alongside, The Five Priorities for Care of the Dying Person document and the individual care plans for care of patients in their last days of life: At this stage, there should have been discussions with the patient and those important to them agreeing the focus of treatment is comfort.

1. The patient may have an altered level of consciousness or significantly reduced oral intake and so struggle to swallow medication. Therefore review current medication and discontinue any medication that is not of benefit.

<table>
<thead>
<tr>
<th>Anti-Hypertensive’s</th>
<th>Corticosteroids</th>
<th>Hypoglycaemics*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti-biotics**</td>
<td>Diuretics**</td>
<td>Iron / Vitamin preparations</td>
</tr>
<tr>
<td>Anti-arrhythmics</td>
<td>Haematinics</td>
<td>Statins</td>
</tr>
<tr>
<td>Anti-coagulants</td>
<td>Hormone therapy</td>
<td>Steroids (long term)</td>
</tr>
</tbody>
</table>

* Please refer to the Diabetic guidelines and the Diabetic Team for management of diabetes in advanced terminal disease.
** It may be appropriate to continue these medications with daily review if there is still a possibility the patient may recover.

2. Medication should be prescribed to manage distressing symptoms, and given by the most appropriate route and dose for each patient. The most common symptoms during the last days of life are:
   - Pain
   - Nausea
   - Agitation / restlessness
   - Noisy breathing (death rattle)
   - Breathlessness

3. Even if these symptoms are not already present, all dying patients should have as required SC medication prescribed for the above symptoms, unless clear reason not to.

4. Medication needs to be reviewed at least every 24 hours. If 2 or more doses of an as required medication are given, consider the use of a syringe driver for continuous SC infusion.

5. The attached guidelines are to help you manage distressing symptoms

6. NB: Morphine Sulphate is also now being used as an alternative to diamorphine in some cases, please ensure you check medication prescribed and contact specialist teams for advice as needed.

7. For patients with Advanced Chronic Kidney Disease (estimated glomerular filtration rate less than 30 ml/min). It is appropriate to follow the above guidance but for medications please refer to the separate medication guidelines for drug prescribing in the last days of life with Advanced Chronic Kidney Disease.

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For Specialist advice please contact:
Your Macmillan Palliative Care Nurse Specialist, Specialist Palliative Care Team, St Barnabas Hospice 01522 511566 or Thorpe Hall 01733 225900

Abbreviations: CSCI = 24h Continuous Sub-Cutaneous Infusion via a syringe driver
NAUSEA AND VOMITING GUIDELINES
for Care of the Dying Patient in the last days of life

If the likely cause of the nausea and vomiting is already known and the patient has obtained relief from existing antiemetics, continue these parenterally, e.g.:

- Cyclizine 50mg PO 8hrly → Cyclizine 100 – 150mg/24hr CSCI, always use water for injection as the diluent with Cyclizine
- Metoclopramide 10mg PO 6hrly → Metoclopramide 30 – 40mg/24hr CSCI
- Haloperidol 0.5-3mg PO 12hrly → Haloperidol 1.5-5mg / 24hr CSCI

If the cause of the nausea and vomiting is unknown or if the patient is not fully controlled, use a broad-spectrum antiemetic following the guidelines below:

- Levomepromazine 6.25mg SC stat and PRN 4-6hrly
  - If > 2 PRN doses given in 24 hrs.
    - Levomepromazine 6.25 – 25mg / 24hr CSCI + 6.25mg SC PRN 4-6hrly
      - If > 2 PRN doses still required in 24 hrs.
        - Levomepromazine 25-50mg / 24hr CSCI + 6.25mg Levomepromazine SC 4-6hrly PRN

NB: Levomepromazine can be sedating at any dose

When nausea and vomiting are controlled revert to oral route if appropriate

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BREATHLESSNESS GUIDELINES
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Identify causes of breathlessness and treat if appropriate

Non-drug management
Explanation / Reassurance / Repositioning / Fan therapy
Cool draft of air / Relaxation techniques

↓

Trial of Oxygen Therapy
If SaO₂ < 90% start O₂ 24% - 28%
Evaluate benefit to patient

↓

Drug Management
If opioid naïve give 2.5 – 5mg Diamorphine* SC PRN
If already on opioids use 1/6th of 24hr dose PRN
Give Midazolam 2.5 – 5mg SC PRN for anxiety / distress

↓

If symptoms persist

Commence CSCI Diamorphine* (add up total dose given in last 24hrs) + Midazolam 10mg
AND
PRN Diamorphine SC (1/6th 24hr dose)
PRN Midazolam 2.5 – 5mg SC

↓

ALSO CONSIDER
Furosemide for pulmonary oedema
For respiratory tract secretions (RTS) refer to RTS Guidelines
Bronchodilator for bronchospasm

*For conversion of oral to CSCI see pain guidelines

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AGITATION / DELIRIUM GUIDELINES
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Consider the cause of the symptom.
Use Midazolam when anxiety is a primary component.
Levomepromazine is more appropriate for individuals where agitation is not caused by anxiety e.g. confusion.

Consider correctable causes such as increased pain, urinary retention or constipation

Midazolam 2.5mg – 10mg SC PRN 1hrly
Or
Levomepromazine 6.25 – 12.5mg SC PRN 4-6 hrly

If > 2 PRN doses given in 24 hrs.

Increase dose according to breakthrough doses given
Midazolam 5-30mg / 24hr CSCI + Midazolam 2.5-10mg SC PRN 1hrly
Or
Levomepromazine 6.25 - 150mg / 24hr CSCI
+ Levomepromazine 6.25 – 12.5 mg SC PRN 4-6 hrly

If necessary combine Levomepromazine with Midazolam
(Seek specialist advice)

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**RESPIRATORY TRACT SECRETION GUIDELINES**
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Because they do not affect existing secretions an antisecretory drug needs to be given promptly as soon as the onset of death rattle is detected. Other causes include pulmonary oedema and gastric reflux.

In a semiconscious patient, if rattling breathing appears to be causing laboured breathing and/or distress, supplement the below with an opioid, e.g. diamorphine and an anxiolytic sedative, e.g. midazolam, both regularly and PRN

<table>
<thead>
<tr>
<th>Hyoscine Butylbromide 10 - 20mg SC stat and PRN 8 hrly</th>
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</thead>
<tbody>
<tr>
<td>If 2+ PRN doses given in 24hrs</td>
</tr>
<tr>
<td>Hyoscine Butylbromide 60 – 120mg CSCI over 24 hrs. + Hyoscine Butylbromide 10-20mg SC stat PRN 8hrly</td>
</tr>
</tbody>
</table>

- **Explanation:** The noisy breathing is due to the presence of secretions in the airways and throat which the patient is generally no longer aware of or bothered by (like snoring).
- **Repositioning:** Semi prone to encourage postural drainage; but upright or semi recumbent if the cause is pulmonary oedema or gastric reflux.

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PAIN CONVERSION GUIDELINES
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<tr>
<th>Patient is in pain (uncontrolled)</th>
<th>Patient’s pain is controlled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the patient already taking opioid medication?</td>
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</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If using MORPHINE calculate total ORAL MORPHINE dose for 24 hrs. Divide by 3 to get DIAMORPHINE dose</td>
<td>Syringe driver DIAMORPHINE 5mg over 24hrs and DIAMORPHINE 2.5mg SC PRN dose</td>
</tr>
<tr>
<td>If using OXydCONE calculate 24hr dose. Divide by 2 to get OXydCONE injection dose for syringe driver</td>
<td>To start a patient from WEAK OPIOIDS start a syringe driver over 24 hrs. with 5-10mg of DIAMORPHINE</td>
</tr>
<tr>
<td>If using FENTANYL / BUTRANS PATCHES see separate algorithm Refer to guidelines or seek Specialist Palliative Care Advice</td>
<td>If using ORAL MORPHINE calculate the 24hour dose and divide by 3 (e.g. MST 30mg bd orally = DIAMORPHINE 20mg via SC syringe driver)</td>
</tr>
<tr>
<td></td>
<td>If using oral OXydCONE calculate 24hr dose. Divide by 2 to get OXydCONE injection dose (e.g. OXYCONTIN 20mg bd = 20mg OXydCONE)</td>
</tr>
<tr>
<td></td>
<td>If using FENTANYL/BUTRANS PATCHES See separate algorithm, refer to guidelines or seek Specialist Palliative Care advice</td>
</tr>
<tr>
<td></td>
<td>A PRN dose should be prescribed in all cases. This should be 1/6th of the syringe driver dose (either DIAMORPHINE or OXydCONE injection)</td>
</tr>
<tr>
<td></td>
<td>After each 24hrs the medication use should be reviewed and if 2 or more PRN doses required then adjust the syringe ring dose/commence syringe driver, also remembering to increase PRN dose.</td>
</tr>
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FENTANYL PATCH IN PLACE

YES

Pain controlled

Continue patch as prescribed

If patient develops breakthrough pain calculate previous 24hr, breakthrough required and convert to CSCI

NO

Not controlled

Start CSCI taking into consideration the previous 24hrs Morphine dose

If patch is newly applied (last 72 hours) remove & Commence CSCI following PANG guidelines (option 2 page 47) at 50% for 24hrs

or

If Long Term patch in place continue with current prescription and leave in place. Ensure prescribed on CD1 form. Calculate previous 24hr breakthrough needed and convert this to be inserted into CSCI

NB: When using Fentanyl and CSCI, Ensure breakthrough dose incorporates both in calculation e.g.: 25mcg patch + Diamorphine 30mg in CSCI = 10mg diamorphine PRN

NB: IF BUTRANS/TRANSEC PATCH IN PLACE – SEEK SPECIALIST ADVICE

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