GUIDANCE FOR SYMPTOM CONTROL IN END OF LIFE CARE

As health care professionals, acceptance of a diagnosis of dying can be difficult but it is one that must be considered and anticipated.

For any ‘unwell patient’, the MDT should be asking ‘would we be surprised if this person dies during this admission/episode of illness?’ If the answer is NO, ensure that this is recognised as part of the differential diagnosis, communicated to the family and patient where appropriate, and planned for.

The principles of good end of life care are:

- effective communication with patients and their families
- regular assessment
- management of symptom control
  - e.g. ensure anticipatory medications prescribed (see below)
- avoid unnecessary interventions e.g. ensuring DNACPR status, the need for ongoing observations/investigations/blood tests reviewed
- provision of psychological, social and spiritual support
- food/fluids as desired – may be appropriate for comfort even if unsafe swallow. Parenteral fluids may be continued/commenced if appropriate.

<table>
<thead>
<tr>
<th>SYMPTOM</th>
<th>USUAL &quot;AS REQUIRED&quot; (PRN) STARTING DOSE</th>
<th>STARTING DOSE FOR SYRINGE PUMP IF NEEDED (Consider if 2 or more PRN doses needed in last 24hrs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAIN / TACHYPNOEA</td>
<td>Must be individualised see algorithm opposite</td>
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<tr>
<td>NAUSEA</td>
<td>Levomepromazine 6.25mg s/c 6 hrly</td>
<td>Levomepromazine 6.25mg s/c over 24 hours *</td>
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<td></td>
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<td>*Due to long half life drug single daily injection often adequate.</td>
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<tr>
<td>AGITATION / DISTRESS</td>
<td>Midazolam 2.5-5mg s/c every 60 mins until settled</td>
<td>Midazolam 5-10mg s/c over 24hrs</td>
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<tr>
<td>SECRETIONS (Review parenteral fluids)</td>
<td>Glycopyrronium 400mg s/c 4hrly</td>
<td>Glycopyrronium 600-1200mcg s/c over 24 hrs</td>
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For palliative care advice

In hours: GRH 0300 422 5179, CGH 0300 422 3447,
Community single point of access: 0300 422 5370.
For out of hours please call the hospital switchboard on 0300 422 2222.
PRESCRIBING SUBCUTANEOUS MORPHINE IN THE DYING PATIENT WHO CAN NO LONGER TAKE ORAL MEDICATIONS

Patient in Pain

Is patient already taking oral Morphine?

Yes

Prescribe anticipatory medication: Morphine 2.5-5mg s/c as required maximum frequency one hourly

Convert the daily oral dose of Morphine including breakthrough medication taken in previous 24 hours to Morphine s/c via syringe pump. To do this divide the total daily dose of oral Morphine by 2.

No

Prescribe ‘as required’ (PRN) doses of Morphine s/c 1/6 of the 24 hour dose in the syringe pump, maximum frequency one hourly.

Pain is controlled

Is patient already taking oral Morphine?

Yes

To convert a patient from oral Morphine to 24 hr s/c infusion of Morphine divide the total daily dose of Morphine by 2.

No

Review at least every 24 hours

Approximate conversions of opioids

Oral Morphine 30mg = s/c Morphine 15mg
Oral Morphine 30mg = s/c Diamorphine 10mg
Oral Oxycodone 30mg = s/c Oxycodone 15mg
Oral Morphine 30-45mg/24hrs = Fentanyl Patch 12mcg/hr

TRANSDERMAL PATCHES:
If already on a Buprenorphine or Fentanyl patch, leave on and add in additional analgesia via syringe pump as above. Remember to include patch strength when calculating PRN doses of Morphine.
NB: Transdermal analgesic patches should not be commenced in the dying phase as there is a long time lapse to reach peak plasma concentrations.

RENAL FAILURE:
Neither Morphine or Diamorphine are advised if eGFR<30mL/min.
Contact specialist palliative care/renal team for advice on appropriate opioid prescribing.