LAST DAYS OF LIFE: SYMPTOM CONTROL GUIDELINES

1. At this stage, the focus of treatment is comfort

2. The patient may have difficulty in swallowing medication, have an altered level of consciousness and much reduced or no food and fluid intake. It is therefore essential to review current medication and discontinue any medication that is no longer necessary, eg

anti–hypertensives	diuretics
antibiotics	haematinics
anti-arrhythmics	hormone therapy
anti-coagulants	*hypoglycaemics
corticosteroids**	oral / adjuvant analgesics
anti-epileptics ***	iron / vitamin preparations

*in insulin dependant diabetics it may be appropriate to continue a small dose of insulin
** it may be appropriate to continue dexamethasone subcutaneously
***if oral anti-epileptics cannot be taken please ensure midazolam is added to the CSCI

3. 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

4. Communication between professionals is essential and the patient and their medication needs to be reviewed at least every 24hrs. The anticipatory prescribing policy is in place to ensure that in the last days/ hours of life there is no delay treating symptoms if they occur.

5. These guidelines are to help you manage symptoms however they are only a guide and you still need to exercise your clinical judgement with each patient.

6. Do not prescribe ranges for syringe drivers - an exact dose of each drug must be prescribed.

7. For PRN doses it is preferable to prescribe an exact dose and the frequency of administration. If a suitable range is prescribed a frequency of administration must be prescribed.

8. WFI (water for injection) is the routine diluent of choice for syringe drivers.

YOU STILL NEED TO EXERCISE YOUR OWN CLINICAL JUDGEMENT WITH EACH PATIENT

All GPs should have a copy of The Palliative Care Formulary and the Palliative Care Pocketbook 3

The Anticipatory Prescribing Policy is in place across Nottingham City and Nottinghamshire to ensure that in the last hours/ days of life there is no delay responding to a symptom if it occurs

For further advice please contact the local Specialist Palliative Care Service

For Nottinghamshire South County and City

For Hayward House ring 0115 9691169 and ask switchboard to bleep the Palliative Care doctor on call for Hayward House.
Advice is available 24 hrs a day

Alternatively call 0115 9934976 to speak to a Community Macmillan Nurse during the hours of 8.30-5.00pm

For Nottinghamshire North of County

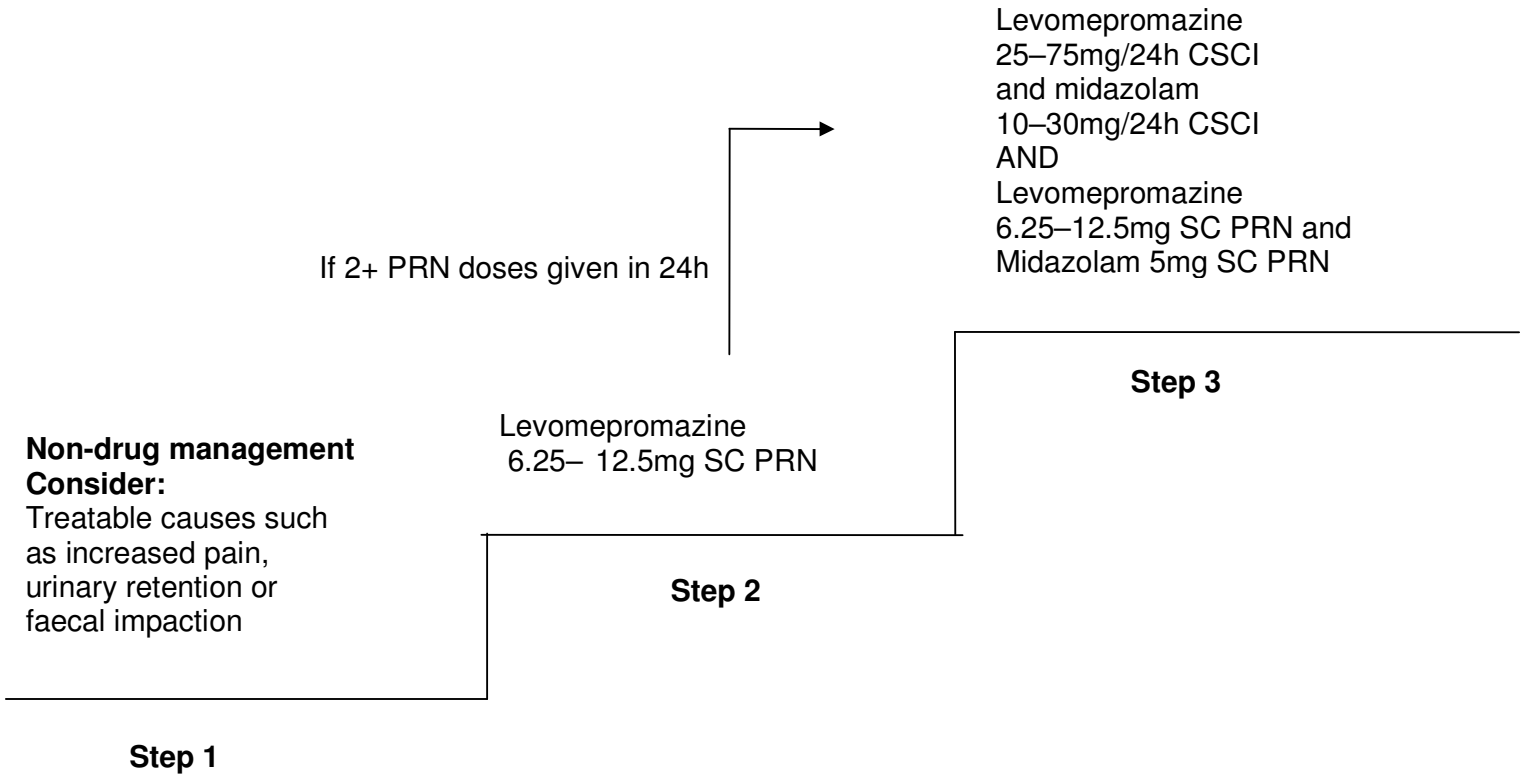
For John Eastwood Hospice ring 01623 622626.
Advice is available 24 hrs a day

For the Specialist Palliative Care Team at Newark ring 01636 685776 during the hours of 8:30-4:30pm.
After 4:30pm Monday to Friday or at weekends ring John Eastwood Hospice on 01623 622626

Abbreviations in the guidelines:

CSCI = 24h continuous subcutaneous infusion via a syringe driver
b.d. = twice daily
t.d.s. = three times daily
q.d.s. = four times daily
TD = transdermal
PRN = as required
PO = oral
SC = subcutaneous
SL = sublingual

Agitation / Delirium Guidelines



If symptoms persist please ask for advice from the local palliative care team

Breathlessness Guidelines

Also consider:
Trial of oxygen therapy if SaO_2 <90% start O_2 2–4 l/min using nasal cannula

Furosemide for pulmonary oedema

Hyoscine butylbromide for respiratory tract secretions

Bronchodilator for bronchospasm

Non-drug management
Consider:
Explanation / reassurance
Repositioning
Fan therapy / cool draft of air
Relaxation techniques

Step 1

If opioid naïve give
2.5–5mg morphine SC PRN
If already on opioids use 1/6th of 24h dose PRN
Give Midazolam 2.5–5 mg SC PRN for anxiety / distress

Step 2

If 2+PRN doses given in 24h

CSCI morphine
(add up total SC dose given in the last 24h) and add Midazolam 10mg/ 24h CSCI
and
PRN morphine SC (1/6th 24hr dose) and PRN Midazolam 2.5–5mg SC

Step 3

1. *Converting PO morphine to SC for syringe driver divide total 24h oral dose by 2*
2. *Converting PRN oral morphine to SC give half the oral dose as SC morphine*
3. *For the PRN SC dose give one sixth of the 24h CSCI dose*

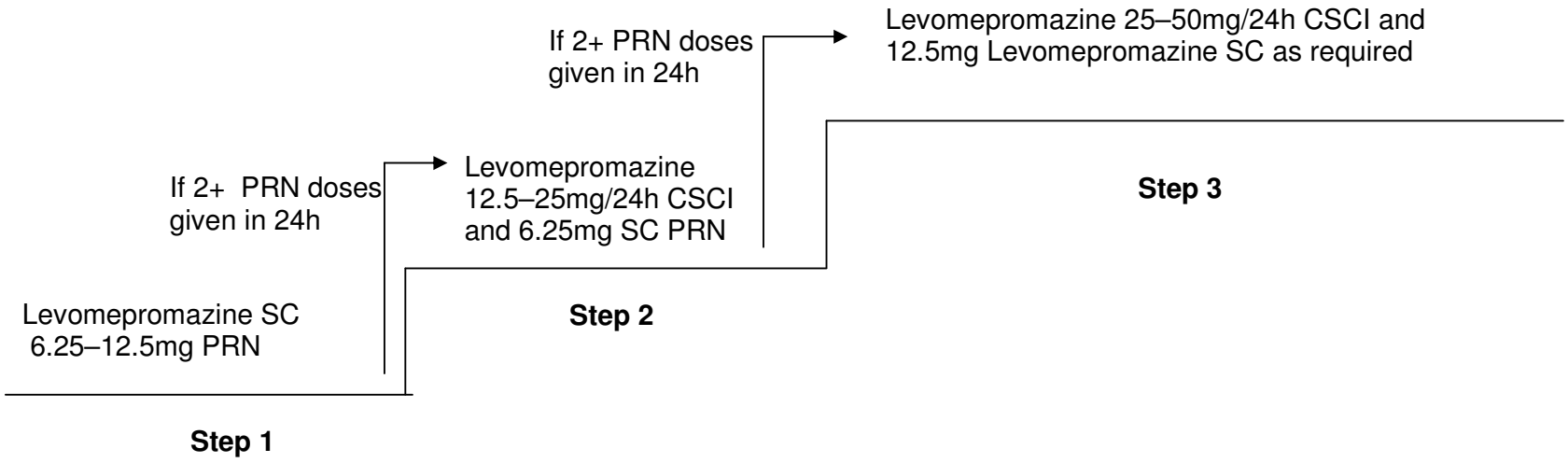
If symptoms persist please ask for advice from the local palliative care team. If the patient is on oxycodone, fentanyl, methadone or other opioids please ring for advice

Nausea and Vomiting Guidelines

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

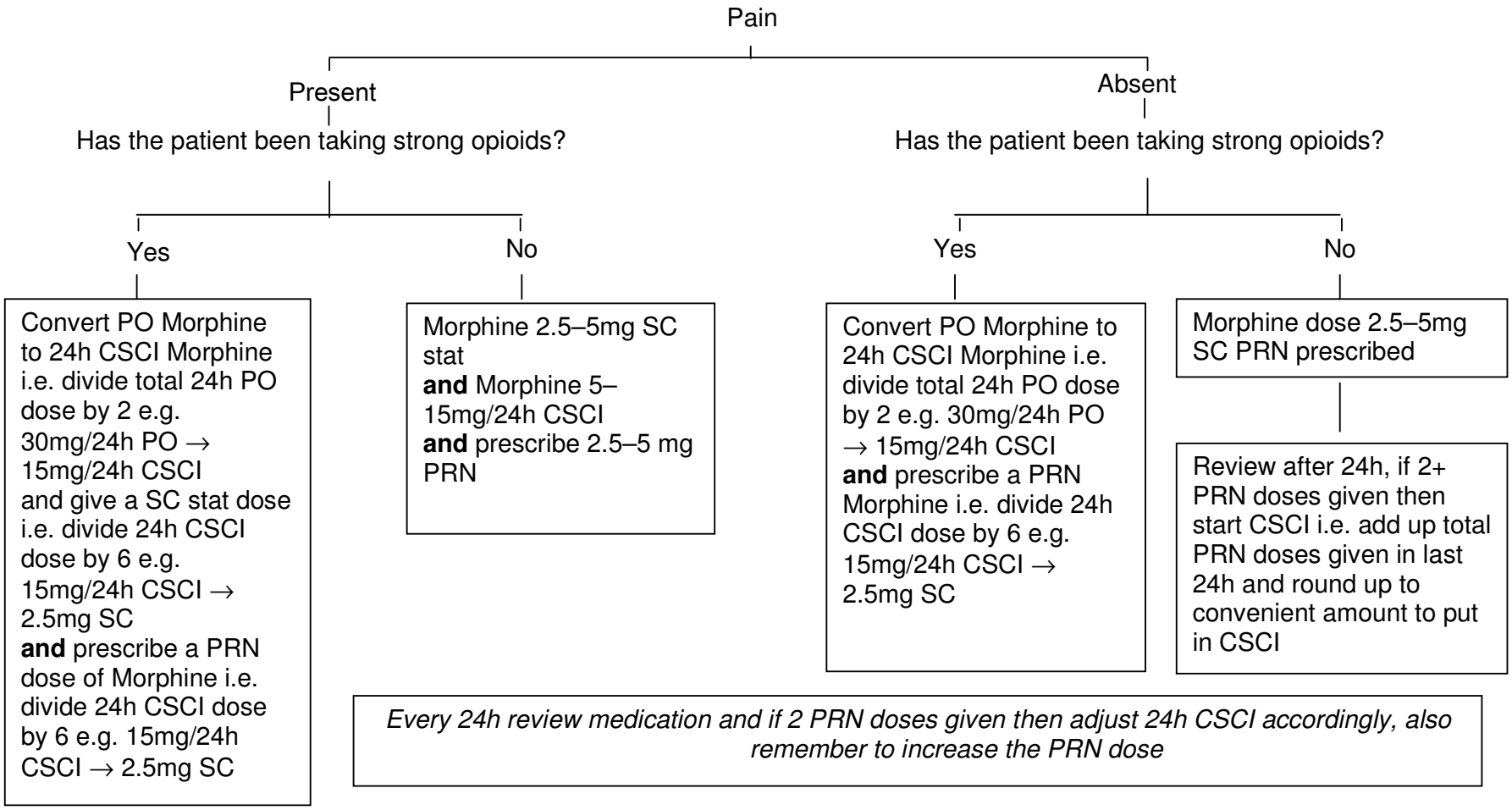
Cyclizine 50mg PO tds → Cyclizine 150mg/24h CSCI (always use water for injection as the diluent with Cyclizine)
Metoclopramide 10mg PO qds → Metoclopramide 40mg/24h CSCI
Haloperidol 1.5–3mg PO bd → Haloperidol 2.5mgs/24h CSCI

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



If symptoms persist please ask for advice from the local palliative care team

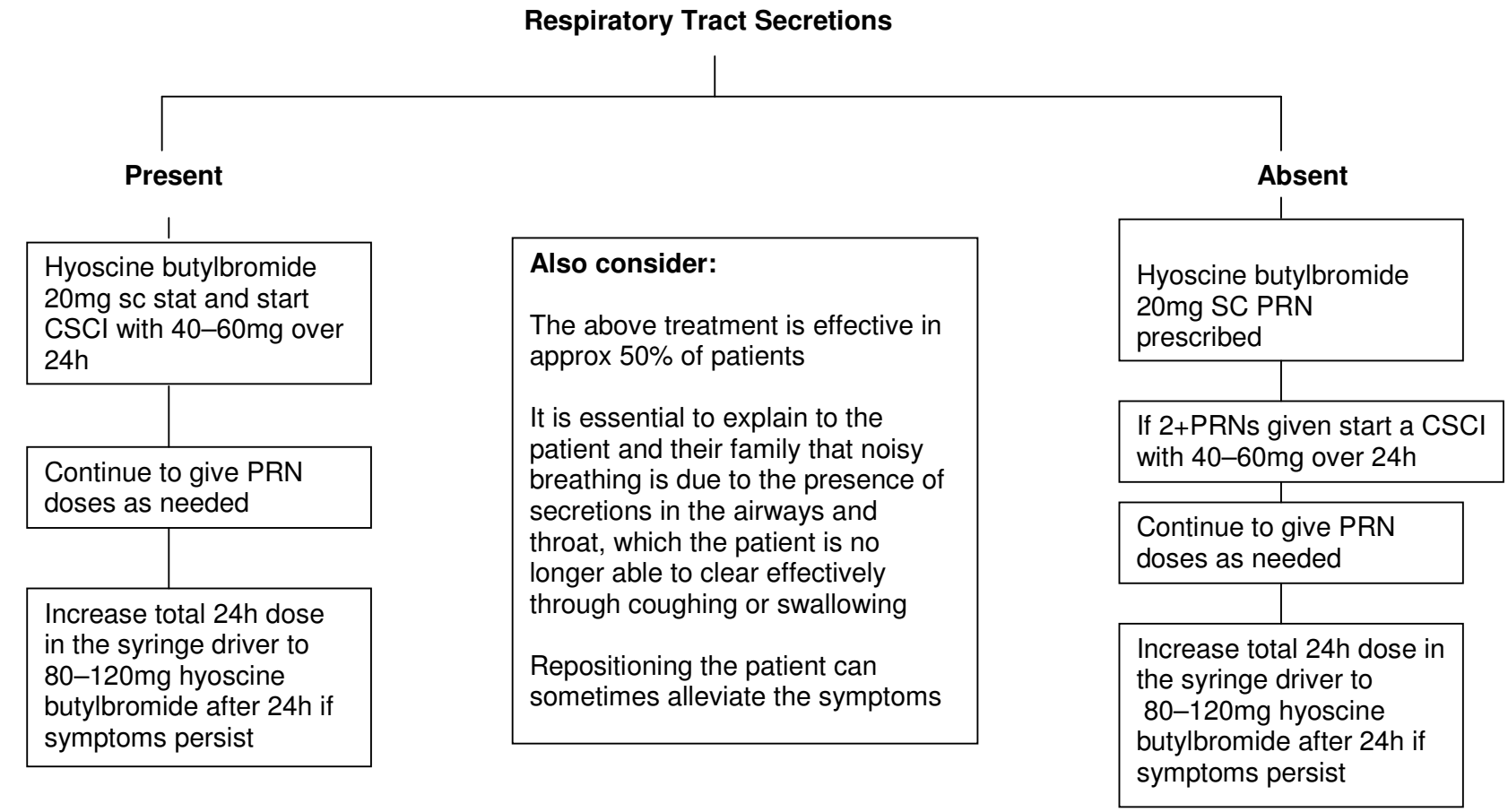
Pain Management Guidelines



Every 24h review medication and if 2 PRN doses given then adjust 24h CSCI accordingly, also remember to increase the PRN dose

If patient on PO Oxycodone, Hydromorphone, Methadone or Fentanyl TD or if symptoms persist please ask for advice from the local palliative care team

Respiratory Tract Secretions Guidelines



If symptoms persist please ask for advice from the local palliative care team