ROYAL TRINITY HOSPICE

Guy's and St Thomas' NHS
NHS Foundation Trust

C020 Guidelines: EOLC Symptom Control for Patients with Normal Renal Function (in Wandsworth)

Summary: This guidance offers the best choice of injectable medications and doses for symptom control at the end of life.

Optimising the patient's medications contributes towards a care plan that is individualised to their needs at the end of life.

Royal Trinity Hospice: 0207 787 1000

Document Detail	
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Ratification by, Date	Clinical Governance Committee, Nov 2019
Superseded documents	V2

Change History		
Date	Change details, since approval	Reviewed by
May 2017	Review	
Nov 2019	Review	

Monitoring Policy Effectiveness

Regular monitoring by Clinical Risk Group

Evidence includes:
Clinical Incidents
Staff feedback.
Audits of practice.
Changes in legal and best practice guidance

Adapted with permission from GSTT EOL symptom control guidelines

End of Life Care symptom control guidance for adult patients: Normal Renal Function

PAIN

For patients already on an analgesic preparation, including another opioid, seek advice from the Specialist Palliative Care Team at Trinity Hospice

Consider:

- Current medications that are controlling symptoms and could be continued
- Pre-existing conditions that may influence prescribing (e.g. renal failure eGFR < 30 mL/ min)
- Non-drug measures (see supporting information on page 2)
- Administer medications according to the current Drug Authorisation Chart

Anticipatory Prescribing – ahead of symptoms appearing or worsening:

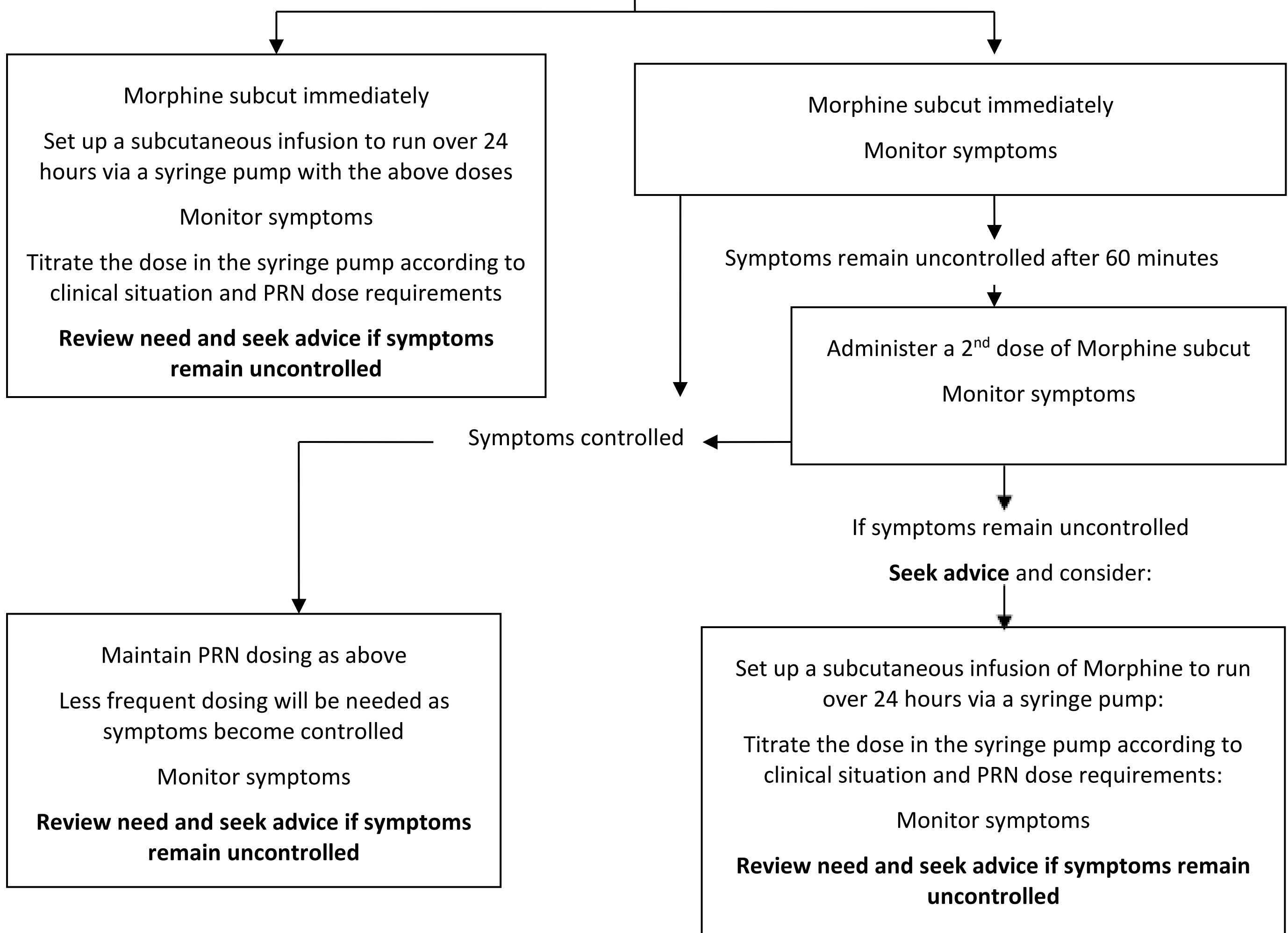
Morphine5mg to 15 mg subcutaneous infusion to run over 24 hours via a syringe pump
Morphine 2.5mg to 5 mg subcut 1-hourly PRN

Consider morphine 1.25-2.5mg sc prn and 2.5-7.5mg in driver over 24 hours for the frail/elderly

Symptoms appear

Consider place of care and practical issues

Administer medications in one of two ways:



Supporting information

- Explain to the patient, their carer(s)/ family what might be causing the symptoms.
- Consider non-drug interventions that may help relieve pain, for example heat pads or re-positioning if appropriate.
- Eliminate potentially reversible causes that may be exacerbating symptoms. Consider:
  - Signs of infection and/ or inflammation.
  - Signs suggestive of obstruction, constipation (including a PR examination if appropriate) and/ or ascites upon abdominal examination.
  - Signs of urinary retention
  - Anxiety and/ or confusion.
- Address any concerns the patient or family may have about opiates or syringe drivers.
- Consider using **subcutaneous Morphine** following the dosing schedule on page 1 if opiate naive.
- Prescribe medication in anticipation of symptoms. A PRN dose should be given immediately symptoms appear, and then when required.
- In practice, after the first 2-3 PRN doses, it would be uncommon for them to be given so frequently.
- Consider setting up a subcutaneous infusion of Morphine to run over 24 hours via a syringe pump where:
  - The patient can no longer swallow oral medications and/ or,
  - More frequent PRN doses are required

For patients already on an analgesic preparation, including another opioid, seek advice from the Palliative Care Team: 0207 787 1000

- When starting a patient on a subcutaneous infusion via a syringe pump who is already on another opioid preparation consider the following for:
  - **Patients currently taking an oral 12-hourly modified release opioid tablet:**
    Start the syringe pump 8hours after the patient takes their final modified release opioid tablet
  - **Patients currently wearing an opioid patch:**
    Leave the patch on. Start a syringe pump containing opioid at a dose based on the PRN opioid usage over the preceding 24 hours. Remember to adjust the new PRN dose of opioid which should be based on the total Opioid dose being administered over 24 hours (i.e. the patch + the subcut syringe pump doses).

  Remember: continue to replace the patch when this is due.
- **If symptoms remain uncontrolled or if you need advice/ support, contact the Palliative Care Team: 0207 787 1000**.

Resources to improve the safety of opioids in clinical practice are available from the London Opioid Safety and Improvement group. Email: losig@gstt.nhs.uk for more information.

End of Life Care symptom control guidance for adult patients: Normal Renal Function

AGITATION AND DISTRESS

Consider:

- Current medications that are controlling symptoms and could be continued
- Pre-existing conditions that may influence prescribing (e.g. renal failure eGFR < 30 mL/ min)
- Non-drug measures (see supporting information on page 2)
- Administer medications according to the current Drug Authorisation Chart

Anticipatory Prescribing – ahead of symptoms appearing or worsening

Midazolam 10mg to 20 mg subcutaneous infusion to run over 24 hours via a syringe pump

plus

Midazolam 2.5 mg subcut 1-hourly PRN

Consider Midazolam 1.25mg to 2.5mg sc prn and 5mg to10mg in driver over 24 hours for the

Symptoms appear

Consider place of care and practical issues

Administer medications in one of two ways

Midazolam subcut immediately

Set up a subcutaneous infusion to run over 24 hours via a syringe pump with the above doses

Monitor symptoms

Titrate the dose in the syringe pump according to clinical situation and PRN dose requirements

Review need and seek advice if symptoms remain uncontrolled

Midazolam subcut immediately

Monitor symptoms

Symptoms remain uncontrolled after 60 minutes

Administer a 2nd dose of Midazolam subcut

Monitor symptoms

Symptoms controlled

Maintain PRN dosing as above

Less frequent dosing will be needed as symptoms become controlled

Monitor symptoms

Review need and seek advice if symptoms remain uncontrolled

If symptoms remain uncontrolled

Seek advice and consider:

Set up a subcutaneous infusion of Midazolam to run over 24 hours via a syringe pump

Titrate the dose in the syringe pump according to clinical situation and PRN dose requirements:

Monitor symptoms

Review need and seek advice if symptoms remain uncontrolled

Supporting information

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- Eliminate potentially reversible causes, in particular pain and discomfort that may be caused by a full bladder or rectum.
- Explain to the patient if possible, the patient's carer(s)/ family what might be causing the symptoms
- If it is necessary to consider sedation this should be discussed with the patient, if possible, and their carer(s)/ family.
- If sedation is required for a patient who lacks capacity then a Deprivation of Liberty Safeguard (DoLS) should be considered.
- Consider using **subcutaneous Midazolam** following the dosing schedule on page 1.
- Prescribe medication in anticipation of symptoms. A PRN dose should be given immediately symptoms appear, and then when required.
- In practice, after the first 2-3 PRN doses, it would be uncommon for them to be given so frequently.
- Consider setting up a subcutaneous infusion of Midazolam to run over 24 hours via a syringe pump where:
  - The patient can no longer swallow oral medications and/ or,
  - More frequent PRN doses are required
- **If symptoms remain uncontrolled or if you need advice/ support, contact the Palliative Care Team.**

End of Life Care symptom control guidance for adult patients: Normal Renal Function

NAUSEA AND VOMITING

Consider:

- Current medications that are controlling symptoms and could be continued
- Pre-existing conditions that may influence prescribing (e.g. renal failure eGFR < 30 mL/ min, Parkinsonism and Epilepsy)
- Non-drug measures (see supporting information on page 2)
- Administer medications according to the current Drug Authorisation Chart
- **If bowel obstruction is suspected, seek advice from the Palliative Care Team**

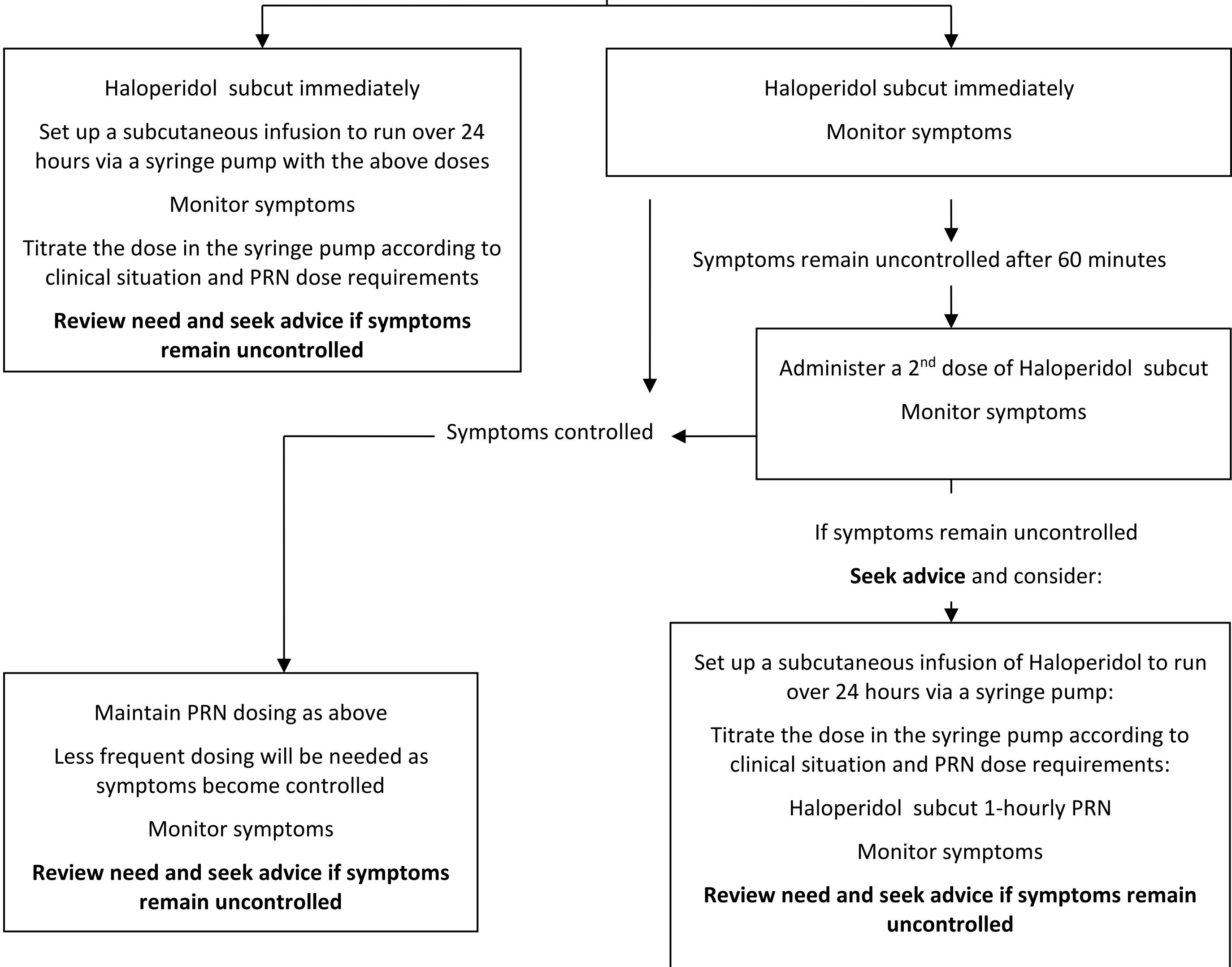
Anticipatory Prescribing – ahead of symptoms appearing or worsening:

Haloperidol 1.5mg to 3 mg subcutaneous infusion to run over 24 hours via a syringe pump
Haloperidol 1.5 mg subcut 1-hourly PRN

Symptoms appear

Consider place of care and practical issues

Administer medications in one of two ways:



Supporting information

- Nausea and vomiting is common in palliative care, with up to 70% of patients being affected in the last week of life.
- Explain to the patient, their carer(s)/ family what might be causing the symptoms.
- Eliminate potentially reversible causes that may be exacerbating symptoms. Consider:
  - Signs of dehydration, infection, raised intracerebral pressure or hypercalcaemia.
  - Oral problems, for example dry mouth or thrush.
  - Signs suggestive of obstruction, constipation (including a PR examination if appropriate) and/ or ascites upon abdominal examination.
  - Anxiety.
- Consider using **subcutaneous Haloperidol** following the dosing schedule on page 1.
- In patients with parkinsonism or epilepsy consider if more appropriate to use cyclizine as first line anti-emetic to avoid exacerbating these conditions.
- Prescribe medication in anticipation of symptoms. A PRN dose should be given immediately symptoms appear, and then when required.

In practice, after the first 2-3 PRN doses, it would be uncommon for them to be given so frequently.

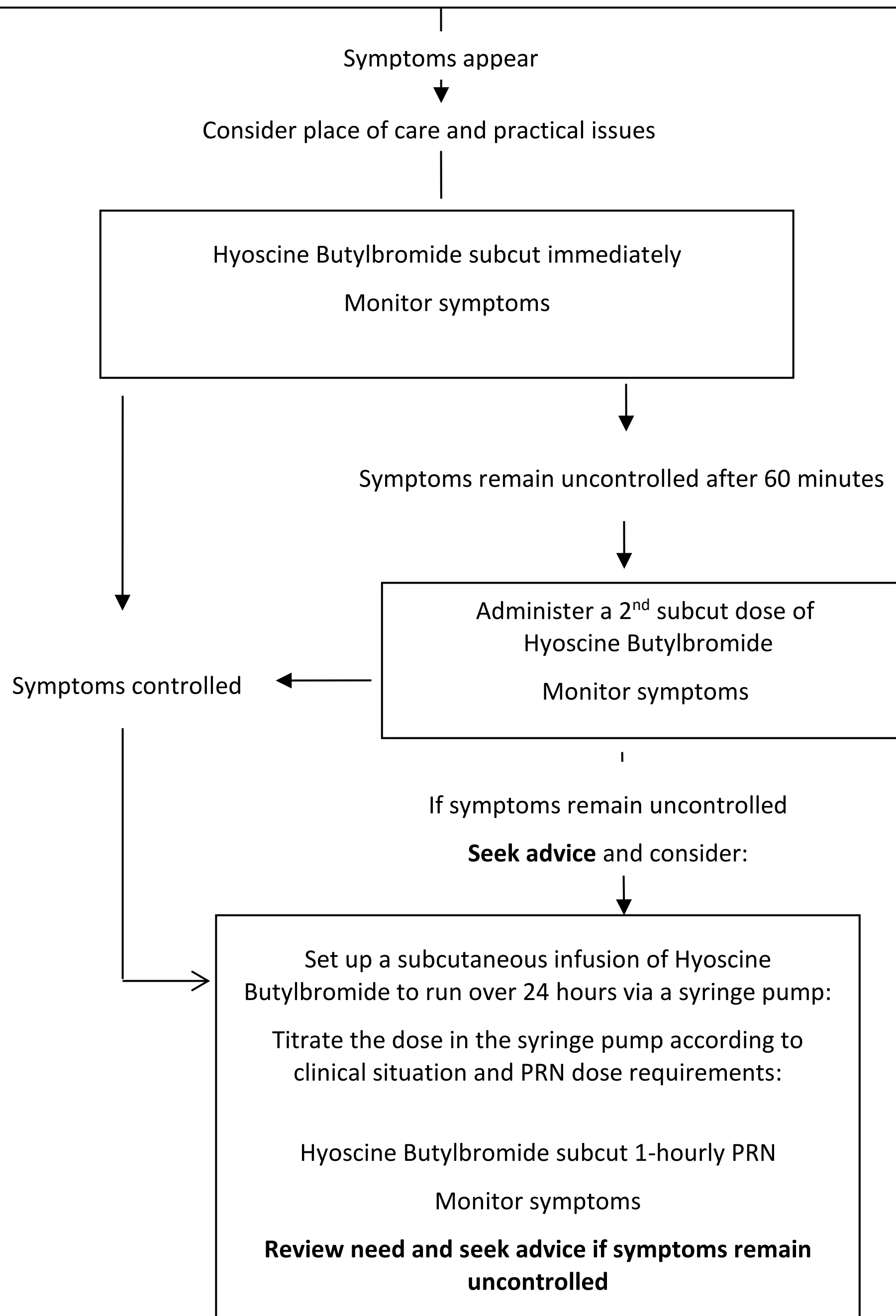
- Consider setting up a subcutaneous infusion of Haloperidol to run over 24 hours via a syringe pump where:
  - The patient can no longer swallow oral medications and/ or,
  - More frequent PRN doses are required
- **If symptoms remain uncontrolled or if you need advice/ support, contact the Palliative Care Team.**

End of Life Care symptom control guidance for adult patients: Normal Renal Function

RESPIRATORY TRACT SECRETIONS

Consider:

- Current medications that are controlling symptoms and could be continued
- Pre-existing conditions that may influence prescribing
- Non-drug measures (see supporting information on page 2)
- Administer medications according to the current Drug Authorisation Chart



Supporting information

- This symptom is usually due to aspirated oropharyngeal secretions and retained bronchial secretions, although in some patients there maybe underlying infection or pulmonary oedema.
- Try to distinguish between airway secretions and soft palate airway noise exacerbated by patients being unconscious.
- Explain to the patient's carer(s)/ family what is causing the secretions/ noise, and that the noise itself is not likely to distress the patient if they are unconscious.
- Repositioning the patient to one side may stop secretions pooling in the pharynx, reducing the noise.
- Anticholinergic drugs have no effect on secretions that are already present but help stop more from developing.
- If infection is present and is being actively managed anticholinergics may make secretions more tenacious and can therefore be unhelpful.
- Suctioning may not be appropriate. Drug therapy is effective in approximately 50% of patients.
- Consider using **subcutaneous Hyoscine Butylbromide (Buscopan)** following the dosing schedule on page 1.
- Prescribe medication in anticipation of symptoms. A PRN dose should be given immediately symptoms appear, and then when required.
- In practice, after the first 2-3 PRN doses, it would be uncommon for them to be given so frequently.
- Consider setting up a subcutaneous infusion of Hyoscine Butylbromide to run over 24 hours via a syringe pump where:
  - More than 1 PRN dose is required
- **If symptoms remain uncontrolled or if you need advice/ support, contact the Palliative Care Team**.