Palliative and End of Life Care Lincolnshire

Policy/Guidelines adopted by:

Community Pharmacy Lincolnshire
EMAS
Lincolnshire Community Health Services (LCHS)
Lincolnshire Medical Council (LMC)
Lincolnshire Partnership Foundation NHS Trust (LPFT)
Lincolnshire Prescribing and Clinical Effectiveness (PACEF)
Lives Trust
Marie Curie Urgent Hospice Care at Home (MC UHCH)
St Barnabas Hospice
United Lincolnshire Hospitals Trust (ULHT)

Lincolnshire Guidelines

Symptom Management in Adult Palliative and End of Life Care

Policy for use across all providers in Lincolnshire

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Ratified by:	EMAS Trust LCHS NHS Trust LIVES Trust LPFT Trust PACEF MC UHCH St Barnabas Hospice ULHT Trust

Policy for Symptom Management in Adult Palliative and End of Life Care
Version Control Sheet

Version	Section/Para/ Appendix	Version/Description of Amendments	Date	Author/ Amended By
12		There was significant review and update of this policy through the Palliative and End of Life Care Programme – Anticipatory Prescribing Task and Finish Group in 2023-2024. Full and further details are documented in the minutes of this group and can be obtained from: governance@stbarnabashospice.co.uk.	February 2024	Full list given below.
12.1	Appendix G	Minor amendment to reviewer / date for review	June 2024	Elaine Wilkins

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Policy for Symptom Management in Palliative and End of Life Care

i. Version control sheet

Contents

1 When to Use

Relieving pain and other symptoms are important in the provision of any health care. These symptom management guidelines are appropriate to use when:

A A patient is deteriorating from an incurable illness and the goal of treatment is prompt symptom control.

AND

B Losing the ability to take or absorb oral medications is foreseeable.

- Drowsiness or weakness e.g., dying patients.
- Vomiting e.g., bowel obstruction.

The majority of these patients will be entering the last days of their lives. They should have an individualised plan of care for achieving comfort and support. The multi-disciplinary team should use these guidelines alongside 'The Five Priorities for Care of the Dying Person' assessments and the individual care plans.

1.1 Other Situations

Subcutaneous (SC) medications and syringe drivers are occasionally required for symptom management in palliative patients who are not in the dying phase.

e.g., uncontrolled nausea and vomiting.

For some patients in hospital there may be uncertainty about whether a patient will recover from an acute illness. It is appropriate to consider symptom management alongside active treatment in this situation.

In these situations, please note the following cautions and consider expert advice:

<u>Hyoscine butylbromide for chest secretions</u>
This can make secretions thicker and more difficult to expectorate. It is normally only appropriate when the underlying cause can no longer be treated AND the patient no longer has an effective cough.

<u>Continuous infusion of midazolam for epilepsy</u>
This can cause drowsiness. It is usually inappropriate if investigation or active treatment of underlying causes is still appropriate.

<u>Morphine and midazolam for breathlessness</u>
Morphine **IS** helpful and safe for relieving chronic breathlessness and midazolam can be useful for associated anxiety. Use both with caution in acute breathlessness where active treatment is ongoing.

2 Reviewing Regular Medication

A patient in last days of life may have an altered level of consciousness or significantly reduced oral intake and therefore struggle to swallow medication. Review current physical and mental health medications and discontinue any medication that is no longer of benefit to the patient – examples below (This list is not exhaustive):

Cardiac Medications	Corticosteroids	Hypoglycaemics*
Antibiotics**	Diuretics**	Iron/Vitamin preparations
Long Term Medications***	Haematinics	Statins
Anti-coagulants	Hormone therapy	Steroids (long-term)***

* Please refer to Section 9 for management of diabetes in advanced terminal disease and consider seeking advice from the Diabetic Team.
** It may be appropriate to continue these medications with daily review if there is a possibility the patient may recover.
*** Consider and plan for risk of agitation when stopping SSRIs.
**** Dexamethasone can be given subcutaneously. Consider continuing steroids via this route if stopping steroids could cause symptoms recurring (e.g., headaches, seizures, or vomiting) or prognosis may be longer than short days. Symptoms will normally take several days to develop.

Some medications **NEED** to continue. Make plans for alternative routes of administration in case the oral route is lost. In hospital a decision needs to be made for each patient about continuing IV administration or switching to the SC route.

Analgesia	Switch to a syringe driver.
Anti-emetics	A syringe driver may provide better symptom management and increased comfort than regular SC doses.
Anti-convulsants	SC midazolam or levetiracetam can be administered via a syringe driver - see section 7.6.

Please see Appendix A for further advice (10 top tips for prescribing at end of life).

3 Anticipatory medications

People's priority at the end of life is to be free from pain and discomfort[1]. The most common symptoms during the last days of life are:

- Pain
- Nausea
- Agitation / restlessness
- Noisy breathing (death rattle)
- Breathlessness

Prescribing anticipatory medication just in case these symptoms occur is accepted practice within the UK[2].

[1] Wood C and Salter J. *A time and a place: What people want at the end of life*. London: Sue Ryder, 2013.
[2] https://www.nice.org.uk/guidance/ng31

In some circumstances informal carers can be taught how to give as required subcutaneous medications in palliative care.

https://www.eolc.co.uk/professionals/lincolnshire-policies-and-guidelines (Lincolnshire Policy for Informal Carers Administration of As Required Subcutaneous Injections in Community Palliative Care)

An individualised approach to each patient is needed.

- Type of medicine and potential benefits and side effects.
- Route.
- Location – consider time to respond to a symptom developing (including prescribing, obtaining and administrating a medicine) e.g., in hospital, this can be done much more quickly than at home.

See the rest of the document for specific conditions and situations such as seizures or regular medication that needs continuing.

A good starting point for patients that have **not** had any recent persistent symptoms:

Medication	Doses	Frequency	Route	Indication	Amount (if at home)
Morphine	2.5-5mg	2 Hourly	SC	Pain or SOB	10 ampoules of 10mg/ml
Midazolam	2.5-5mg	2 Hourly	SC	Anxiety or SOB	10 ampoules of 10mg/2ml
Levomepromazine	3.125-12.5mg	2 Hourly	SC	N + V or agitation	10 ampoules of 25mg/1ml
Hyoscine Butylbromide	20mg	2 Hourly	SC	Respiratory secretions	10 ampoules of 20mg/1ml

For a person being cared for in the community, please also prescribe water for injection (10 ampoules of 10ml) for use as directed.

This plan must be individualised to the patient's needs and wishes. Please see Appendix B for a table of medications commonly used for symptom management in palliative care.

It is vital that the lowest effective dose is used. The dose can be titrated as required. When a dose range is prescribed for PRN medication, it is acceptable to repeat a lower dose within the minimal interval providing the maximum dose is not exceeded within that time range.

Availability and cost of different medications can vary over time. Local information sharing resources and discussions with your local pharmacist can support cost-effective prescribing without any additional delays due to challenges sourcing medication. Resources will be added to www.eolc.co.uk as they become available.

3.1 Anticipatory Symptom Management for People Dying from Acute Infections

Patients dying of COVID-19 or other acute infections may deteriorate rapidly with severe symptoms. These patients may require a lower threshold for dose escalation.

Medication Options

The medications most likely to provide effective symptom control are:

- Anti-pyrectics for rigors and delirium
- Opioids for dyspnoea and cough
- Benzodiazepines for agitation
- Anti-psychotics for delirium and agitation

The rapid onset of severe symptoms means that stat doses of subcutaneous drugs may result in faster and better symptom relief.

4 Reviewing and Titrating Medication

Health care professionals should:

- Assess a dying person's comfort daily.
- Review medication needs and possible side effects at least daily.

Please see Diagram 1 (Page 8).

Starting a syringe driver (Continuous Subcutaneous Infusion (CSCI)

- A syringe driver allows medication to be administered continuously over a 24 hour period to provide optimal symptom management for persistent symptoms.
- Start a syringe driver to replace regular symptom control medications if a patient is unable to swallow or absorb medications via the oral route for reasons such as:

    - Persistent nausea and vomiting
    - Severe swallowing problems
    - Severe dysphagia
    - Bowel obstruction
    - Malabsorption
    - Reduced level of consciousness (such as last days of life)

Also see Section 2.

- Consider starting symptom control medication regularly if a patient experiences persistent or repeated symptoms. This can be evidenced by:
    - Repeated doses of PRN medication for symptom control (e.g., 2 or more doses)
    - Reports or observations of persistent or repeated symptoms in the previous 24 hours (even if no PRNs have been administered).

- Use a syringe driver if the patient is unable to swallow or absorb medication by the oral route.
- Consider reversible causes and non-drug treatment options (see Section 7).
- Syringe drivers may be used prior to the last days of life for symptom management when the oral route is not appropriate or possible to use.
- It may be appropriate to start a syringe driver for intractable symptoms, which can then be stopped if symptoms stabilise and managed orally.

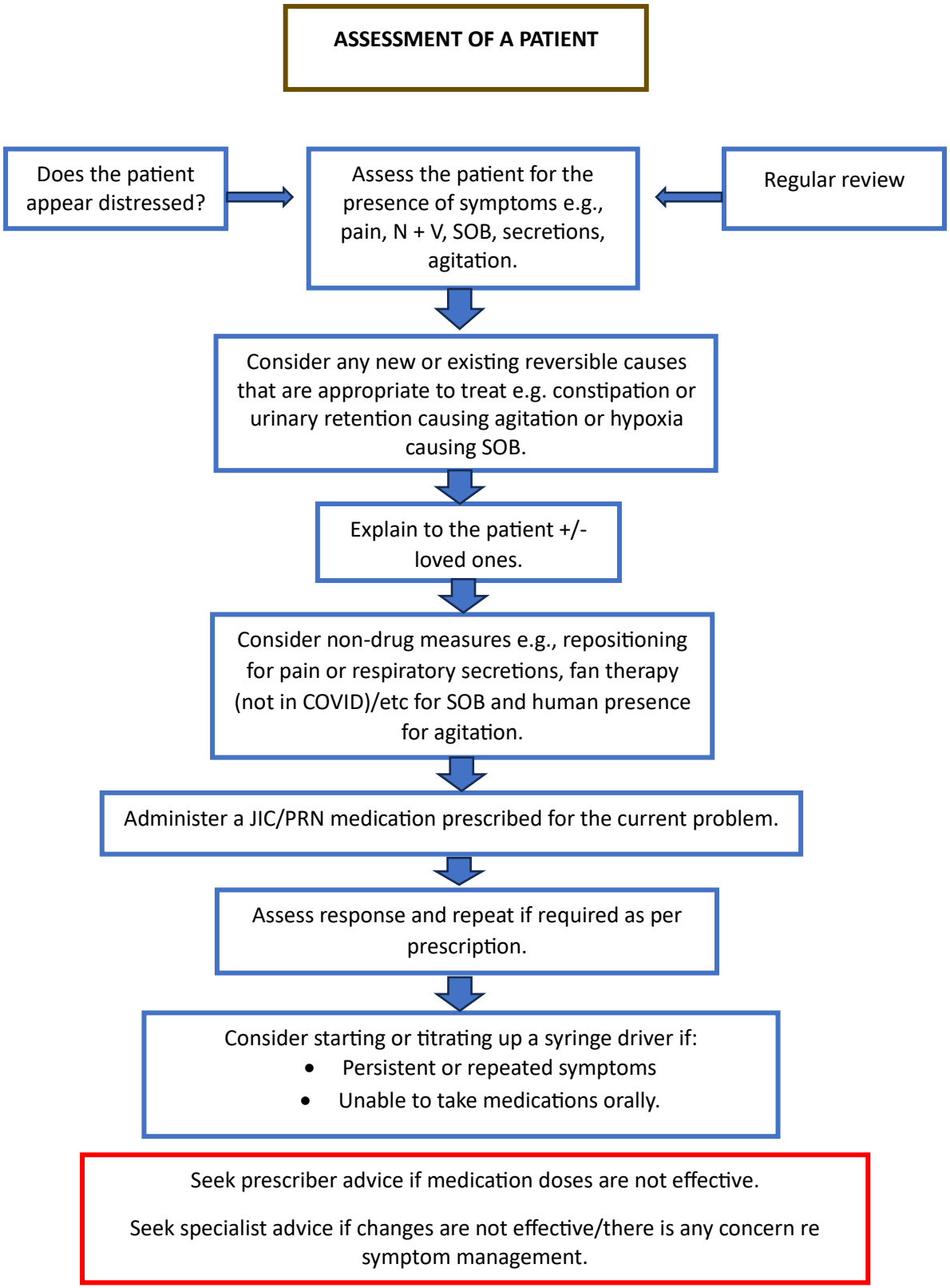
Titrating regular medication

- If a patient is experiencing persistent or repeated symptoms despite regular medication, review the dose and medication needed:
    - If PRN doses are effective, titrate up regular medication.
    - If PRN doses are ineffective or side effects are present, consider an alternative medication.

- Consider seeking specialist palliative care advice (see Section 6)
- All of the above needs to be individualised to the patient wishes.

Please see **Appendix B** for specific drug information.

Diagram 1



5 Drug Compatibility

For advice and guidance with regards to drug compatibility please refer to the Palliative Adult Network Guidelines 2024: Palliative Care Matters (pallcare.info)

6 Specialist Palliative Care Advice

Specialist palliative care advice is available across Lincolnshire from:

- St Barnabas Hospice In-Patient Unit, Lincoln
  - 24-hour advice line 0300 303 1754 or 01522 511566

- LCHS Macmillan Nurses
  - North West 01522 340903
  - South East 01775 652283
  - North East 01522 459899
  - South West 01522 449787

- Thorpe Hall Hospice, Peterborough
  - 24-hour advice line 01733 225900

- Specialist Palliative Care Team ULHT
  - Lincoln County Hospital Monday to Friday 01522 572389
  - Pilgrim Hospital Boston, Monday to Friday 01205 445291
  - Grantham Hospital, Monday to Friday 01476 464988

It is important for health care professionals to know how to contact an appropriate source of specialist advice – either a specialist team that knows the patient or the local arrangements for the organisation. If in doubt, please contact one of the above teams who will be able to signpost you to the most appropriate team.

Patients, carers, family members, Nursing or Residential Home, or **EMAS** teams can also access advice and support from:

- Palliative Single Point of Access (pSPA)
  - 24 hours a day, 7 days a week 0300 123 4868 (press option 10)

Seek specialist advice if:

- A patient does not respond to the prescribed medication.
  - This includes reaching usual maximum doses of a drug over a 24-hour period.
  - Repeated increases in regular doses without significant improvement in the symptoms

- A patient needs multiple PRN doses within a 24-hour period.
- Concerns about possible side effects.
- Any concerns that a patient is continuing to experience distress despite appropriate interventions.
- Support is required regarding how best to support a dying patient and their loved ones.

7 Management of Specific Symptoms

7.1 Pain

Existing symptom management in place

- People who are already on regular oral analgesia need a plan for an alternative administration route if they lose the ability to swallow.
- A continuous SC infusion via a syringe driver is usually used. It is **NOT** appropriate to start a transdermal patch at this time.
- To determine the likely dose (see examples below):
  - PO morphine to SC morphine – divide **total** daily dose by 2.
  - PO morphine to SC diamorphine – divide **total** daily dose by 3.
  - PO oxycodone to SC oxycodone – divide **total** daily dose by 2.
  - PO morphine to SC alfentanil – divide **total** daily dose by 30.

- Please see Diagram 2 (Page 11) for patients on a fentanyl patch. For patients on a buprenorphine patch (BuTrans or Transtec) seek specialist advice.
- Please see Appendix C for an opioid conversion table or use opioid conversion calculator at https://book.pallcare.info/index.php

Anticipatory or PRN prescribing

- Remember people may still be able to manage PO medication.
- People who are not on regular opioid medication should have an opioid prescribed:
  - Morphine 2.5-5mg SC 2 hourly.

- People who are already on regular opioid medication need the appropriate PRN dose calculated:
  - Divide total daily syringe driver dose by 6.

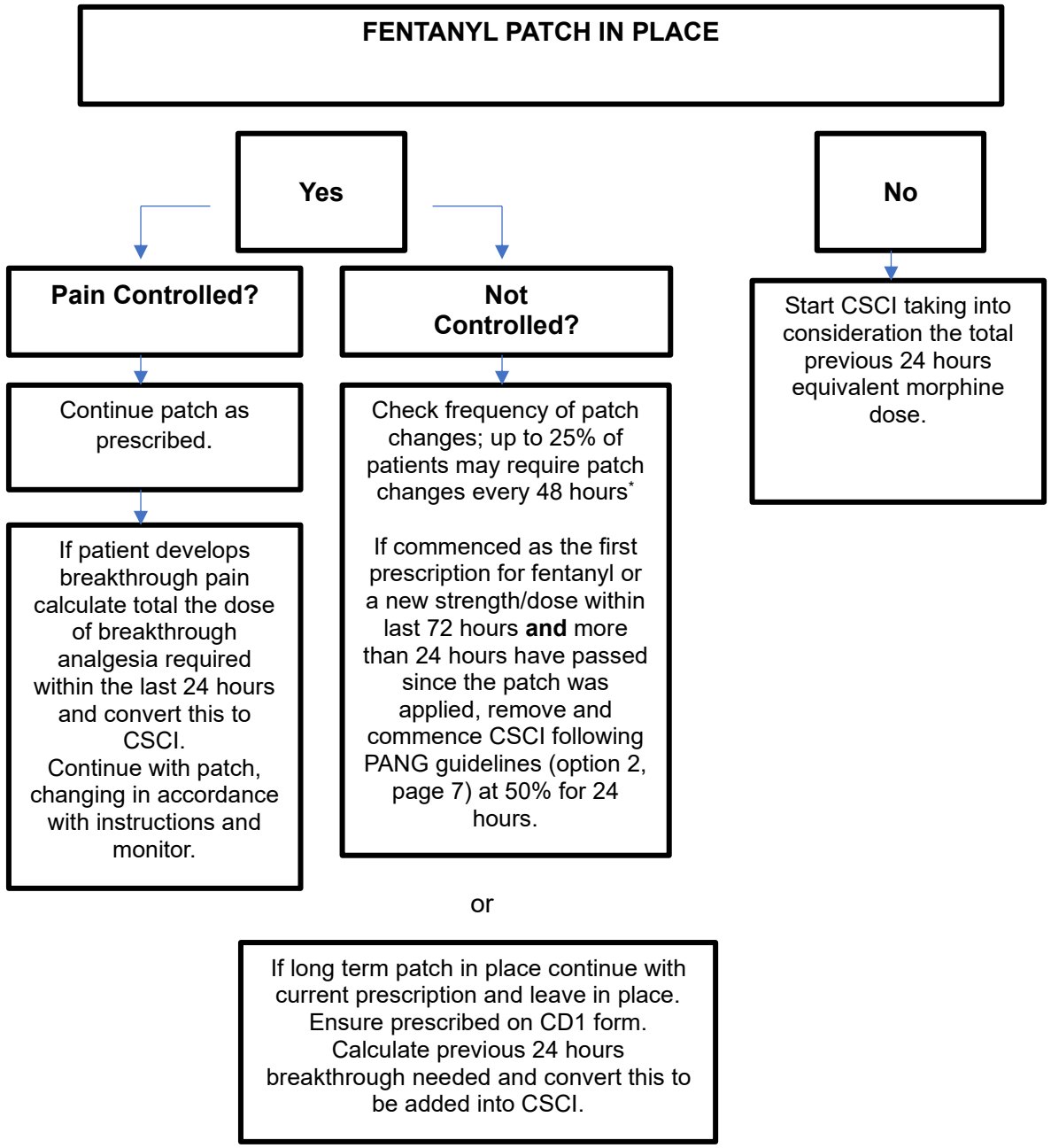
- If PRNs administered or persistent/recurrent pain reported, consider starting a syringe driver (starting doses on CD1 form). See Section 4.

Individualising care

- People can be frightened by morphine/opioids. Discuss and address concerns.
- Consider specific needs for assessing pain for people with learning disabilities or dementia.
- Use appropriate opioid and dose according to a person's previous needs.
- For patients with an eGFR <30, consider using alfentanil or reducing dose and frequency of morphine/oxycodone.
  - PRN Alfentanil is short acting. If it is ineffective for managing breakthrough pain, consider an equivalent dose of SC morphine or SC oxycodone.

- Starting opioid doses can be reduced in cachectic and older people with frailty e.g., morphine 1-2.5mg.
- PO/PR paracetamol may be appropriate to consider for the right patient in the right environment.

Diagram 2



NB: When using Fentanyl and CSCI together there is an increased potential for drug errors. Ensure breakthrough dose incorporates both in calculation: 25 microgram patch and Morphine 20mg in CSCI = 10mg Morphine PRN.

NB: IF BUTRANS/TRANSTEC PATCH IN PLACE - SEEK SPECIALIST ADVICE to support appropriate decisions for the patient. Higher strength patches can be managed in the same way as Fentanyl patches. It may be appropriate to remove low strength patches and only use CSCI.

YOU STILL NEED TO EXERCISE YOUR OWN CLINICAL JUDGEMENT WITH EACH PATIENT AND DISCUSS DECISIONS WITH THE PATIENT WHERE POSSIBLE AND/OR THOSE IDENTIFIED BY THE PATIENT TO BE INVOLVED WITH DECISIONS (eg: LASTING POWER OF ATTORNEY: HEALTH AND WELFARE)
https://book.pallcare.info/index.php?tid=234&searchstring=converting%20fentanyl%20patch%20to%20morphine%20syringe%20driver

7.2 Nausea and Vomiting

Existing symptom management in place

- If regular anti-emetics are effective, continue them as a syringe driver where possible.
- Conversion ratios may differ (for example):
  - Metoclopramide 1:1 10mg tds PO or IV (=30mg/24 hours) = 30mg/24 hours SC cyclizine 1:2 50mg tds (150mg/24 hrs) PO/IV = 75mg/24 hours SC.

Anticipatory or PRN prescribing

- If a particular cause of N+V can be anticipated, consider prescribing an appropriate anti-emetic:
  - Metoclopramide for bowel obstruction/delayed gastric emptying.
  - Cyclizine for brain tumours.

- A broad-spectrum anti-emetic can be prescribed if no cause identified or other anti-emetics ineffective. Regular haloperidol may be as effective as the cause-based approach described above[3].
  - Haloperidol 500micrograms-3mg PO/SC 2 hourly PRN

- Levomepromazine is commonly used in Lincolnshire (for example):
  - Levomepromazine 3.125-12.5mg SC 2 hourly PRN.

- If PRNs administered or persistent/recurrent nausea or vomiting reported, consider starting a syringe driver. See Section 4.

Individualising care

- Levomepromazine can cause drowsiness - if this occurs or a patient is concerned:
  - A smaller starting dose can be tried e.g., 3.125mg SC PRN.

- If the prescribed anti-emetic is not effective, consider an alternative drug or obtaining specialist advice.
- Haloperidol and metoclopramide should be avoided in people with Parkinson's and Lewy Body Dementia. Levomepromazine can exacerbate symptoms in Parkinson's Disease so monitor use.

NB: MHRA guidance (August 2013) regarding restricting the use and dose of metoclopramide does not apply to its use in palliative care.

7.3 Agitation

Existing symptom management in place

- This usually develops during the dying phase. If a person has already required benzodiazepines for anxiety or anti-psychotics for an agitated delirium, then consider

[3] A randomized open-label study of guideline-driven antiemetic therapy versus single agent antiemetic therapy in patients with advanced cancer and nausea not related to anticancer treatment. Hardy et al. BMC Cancer. 2018 May 2;18(1):510. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5932901/

starting a syringe driver with midazolam and/or levomepromazine or haloperidol once they are unable to manage this orally.

Anticipatory or PRN prescribing

- It is useful to have both midazolam and levomepromazine prescribed.
- Midazolam is helpful for anxiety/fear and emotional distress:
  - 2.5-5mg SC 2 hourly PRN.

- Consider Levomepromazine or Haloperidol if there is an associated delirium:
  - Levomepromazine 3.125-12.5mg SC 2 hourly PRN.
  - Haloperidol 500micrograms-3mg PO/SC 2 hourly PRN

- If PRNs administered or persistent/recurrent agitation reported, consider starting a syringe driver. See Section 4.

Individualising care

- Both midazolam and levomepromazine are sedating – this needs to be discussed with the patient/family before commencing.
- Consider reversible causes and non-drug measures (for example):
  - Urinary retention or constipation.

- Explanations can reduce fear.
- Consider environmental changes as per managing delirium in any clinical situation.
- Consider a person's religious or spiritual needs. Support from a chaplain or person's own faith leader should be offered.
- Start with smaller doses and titrate as needed. For patients with continuing symptoms, higher doses can be recommended by specialist palliative care clinicians.

7.4 Respiratory Secretions

Existing symptom management in place

- Medication reduces the volume of chest secretions but sometimes makes them more tenacious.
- Use when underlying causes are no longer being treated and once the patient is too weak to cough.
- Benefit is limited but most patients are not distressed by this symptom. Explanation of this to patients and families is a vital part of treatment.

Anticipatory or PRN prescribing

- Hyoscine butylbromide is the usual drug of choice. It does not cause agitation and can be used at the same dose in renal failure:
  - Hyoscine butylbromide SC 20mg.

- Alternative:
  - Glycopyrronium SC 200 microgram – see National Palliative Adult Network Guidelines 2024: http://www.book.pallcare.info/

- Anti-muscarinic drugs are better at preventing secretions developing rather than treating existing secretions. Consider starting early e.g. if a single PRN dose has been effective after 30 mins.

Individualising care

- Consider whether treatment aimed at aiding expectoration would be more appropriate: e.g., chest physiotherapy; saline nebulisers; PO carbocisteine.
- Explanation to patient and/or family – this is very important as this symptom does not always respond to medication. See BBC Sounds clip by Dr Kathryn Mannix for a good way to discuss this with family.
  https://www.bbc.co.uk/ideas/videos/dying-is-not-as-bad-as-you-think/p062m0xt
- Non-drug measures e.g., repositioning.
- Medications will worsen a dry mouth. Prioritise mouth care.
- Consider stopping any local drying of secretions solutions in use like atropine drops for patients with MND when commencing sub cutaneous options (see **Appendix D** for options for MND patients).

Occasionally treatment of an underlying cause such as infection or heart failure is appropriate. Consider specialist discussion.

MHRA/CHM advice (February 2017) regarding the risk of serious adverse events with hyoscine injection in patients with underlying cardiac disease. This is unlikely to be an issue in patients who are recognised to be already dying who require symptom control. Specialist palliative care advice can be requested in the case of patients with significant recent cardiac problems.

7.5 Breathlessness

Existing symptom management in place

- Some patients may be on regular opioids – convert to syringe driver as per pain guidance.
- Patients already on oxygen – oxygen therapy may be helpful, but the burden of treatment may outweigh the benefit. It is appropriate to discuss this on an individual basis.

Anticipatory or PRN prescribing

- PRN opioid and PRN midazolam are recommended. Midazolam is most effective when there is anxiety associated with breathlessness:
  - Morphine 2.5-5mg 2 hourly PRN.
  - Midazolam 2.5-5mg 2 hourly PRN (usually given second line).

- For management of acute SOB following with withdrawal of respiratory support, seek specialist advice or follow local guidance.
- If PRNs administered or persistent/recurrent breathlessness reported, consider starting a syringe driver (starting doses on CD1 form). See Section 4.

Individualising care

- Non-drug measures can be very useful.

- Explanation and reassurance.
- Repositioning.
- Fan therapy - fan therapy not recommended in airborne infections (e.g., COVID-19).

- Oxygen therapy may be helpful for hypoxic patients, but the burden of treatment may outweigh the benefit. It may not be appropriate for a patient who wishes to minimise medical devices or interventions at this time. Seek advice from specialist if uncertain re: it's use at end of life.
- Further information can be found in the British Thoracic Society Guidelines for Home Oxygen Use in Adults (2015)

https://eolc.co.uk/professionals/oxygen

https://www.brit-thoracic.org.uk/document-library/guidelines/emergency-oxygen/bts-guideline-for-oxygen-use-in-healthcare-and-emergency-settings-summary-of-recommendations/

7.6 Prevention and Management of Seizures

- Anti-epileptics are usually started after a first seizure where there is an irreversible cause (e.g., brain tumour, MS). They should not be used prophylactically.
- Uncontrolled seizures can cause significant distress. Anti-epileptics need to be continued by an alternative route if the patient is unable to swallow or absorb oral medication (e.g., vomiting or in last days of life). This is usually via the SC route in non-acute settings or in last days of life.
- Choice of medication in the syringe driver will depend on previous anti-epileptic treatment and any preferences around avoiding sedative medication.
  - Midazolam 20mg-30mg/24hrs via a syringe driver – this is sedating.

- In situations where less sedation is preferable, specific anti-seizure medications such as levetiracetam can be administered by a syringe driver. This will require planning and initiating under specialist advice.
- If a patient is on dexamethasone due to a brain tumour this may need to be continued via a SC route (4mg PO = 3.3mg (3.3mg/ml) SC) (see Individualising Care below).

Anticipatory or PRN prescribing

- For patients at risk of seizures (known history, presence of brain tumour or other structural brain lesion) consider having one or both of following options available:

  Buccal midazolam 10mg/2ml
  - Administer if seizure lasts longer than 5 minutes and repeat once after 10 minutes if seizure persists.
  - Family member or carer can administer single dose after 5 minutes if appropriate (requires discussion, agreement and training. Family should alert health professional if seizure occurs).
  - SC midazolam 5-10mg stat and repeat once after 10 minutes if seizure persists.

If seizure still persists, seek specialist advice, refer to focus of care on ReSPECT form. Patient may need transfer to acute setting if appropriate/in line with patients' preferred place of care.

Individualising care

- Choice of medication in syringe driver will depend on previous oral anti-epileptic treatment and if there are preferences around avoiding sedative medication.

- Situations where levetiracetam may be of benefit over midazolam:
  - Loss of safe swallow prior to last days of life.
- Variability of conscious level or swallow prior to last days of life leading to difficulties taking oral medication consistently.
- Nausea and vomiting prior to last days of life.
- Patient stable on oral version and planning in advance for loss of swallow.
- High dose steroids may need to be reduced due to size of injection, especially in community settings. For patients who have a vasogenic tumour or difficult to control seizures, consider if appropriate to increase doses of anti-epileptics in a syringe driver or whether possible to facilitate twice daily injections of steroids.

8 Renal Failure

Renal impairment is an important consideration when prescribing drugs, in particular opioids, as metabolites can accumulate in renal impairment and may lead to significant toxicity. Prescribing needs to be individualised to the patient and alternative medications considered if the patient is showing signs of drug toxicity.

In general, most medications are not excreted well in Advanced Chronic Kidney Disease (ACKD). Once administered, a drug may have a longer duration of effect than expected. It is important to choose medications that are less likely to accumulate and cause adverse effects.

- Using smaller doses and increasing dosing intervals can help to reduce drug toxicity. Increasing time between doses may be required with regular medication as well as PRNs.
- It is very important to titrate the medication carefully and frequently review the patient as considerable variation between patients can exist.

With regard to the management of pain and dyspnoea, the evidence for the use of opioids in renal failure is limited. However, these guidelines aim to provide symptom control safely and without development of symptom toxicity.

<u>Indications for use</u>

Individualising PRN and syringe driver prescribing to take into account impaired renal function should be done if a patient has:

- Chronic kidney disease stage 4 or 5 (i.e., estimated glomerular filtration rate (eGFR) of less than 30ml/min/1.73m^2) in which active treatment (including dialysis) is considered inappropriate or has been discontinued.
- Acute kidney injury with rapidly deteriorating renal function from any cause in which active treatment (including dialysis) is considered inappropriate or has been discontinued.

Use the following table to individualise treatment for each symptom that may occur:

Pain	Consider using alfentanil or reducing dose and frequency of morphine/oxycodone. PRN Alfentanil has a shorter duration and may be ineffective in severe prolonged pain. If this occurs, reassess the patient and consider a trial of small doses of PRN morphine or oxycodone.
Breathlessness	Consider reducing the dose and frequency midazolam. PRN Alfentanil has a shorter duration and may be ineffective in severe breathlessness. If this occurs, reassess the patient and consider a trial of small doses of PRN morphine or oxycodone.

Agitation	Increased and prolonged sedation can be caused by both midazolam and levomepromazine. Consider reducing the dose and frequency. Haloperidol may be used as an alternative.
N + V	Levomepromazine can still be used but may cause increased sedation. Haloperidol is an effective anti-emetic if renal failure is the cause of the symptoms.
Respiratory Secretions	Hyoscine butylbromide is safe in patients with renal failure.

9 Diabetic Management

Diabetes can often co-exist with other diagnoses in a patient who is deteriorating and approaching the end of their life. Particular considerations include:

- Fine control of blood sugar is no longer appropriate as the end-of-life approaches and may be very difficult, especially in the presence of liver disease, poor appetite, and weight loss. It can also cause an added burden to the patient and their family.
- It is important to avoid persistent symptomatic hyperglycaemia and equally to avoid hypoglycaemia.
- It can be difficult to identify symptoms due to hypoglycaemia or hyperglycaemia in a dying patient.

Goals of Treatment

- Maintain blood glucose usually between 6 and 15 mmols/l to prevent hypoglycaemia and symptomatic hyperglycaemia.
- Keep tests to a minimum.
- Avoid complex insulin regimes.

Diabetic Management

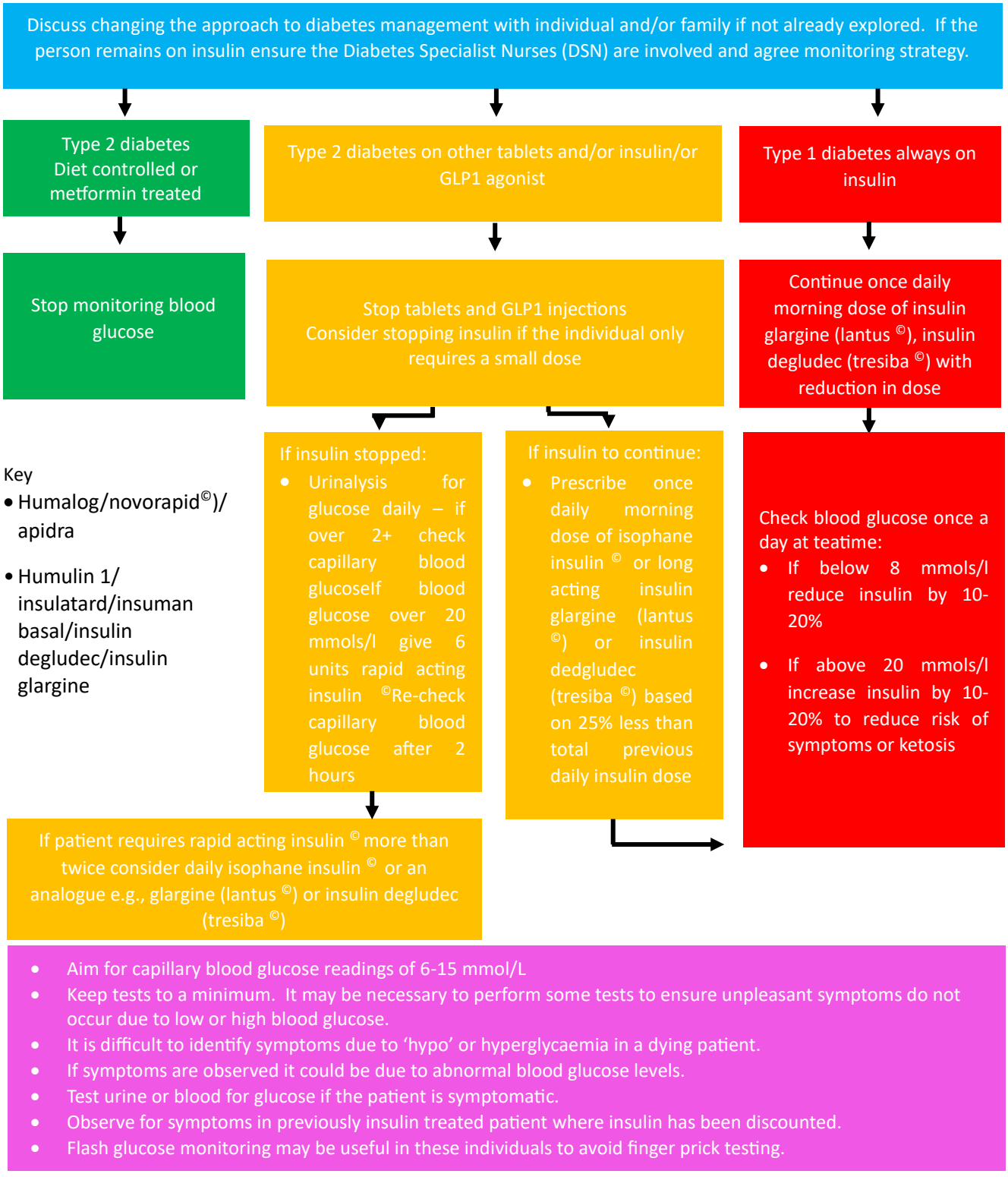
The distinction between the two types of diabetes is important at the end of life because it determines how diabetes is managed. Patients with Type 1 diabetes will require lifelong insulin, whereas with Type 2 diabetes it is likely that neither oral hypoglycaemic agents nor insulin treatment will be required as the end-of-life approaches and blood glucose levels fall, due to a combination of poor appetite and weight loss.

Discuss management changes with the patient where possible and with their family.

Please refer to the current End of Life Care Guidance for Diabetes Care (endorsed by Diabetes UK) or contact your local Diabetes Team.

https://www.diabetes.org.uk/professionals/position-statements-reports/diagnosis-ongoing-management-monitoring/end-of-life-care

Figure 1 - Algorithm for the last days of life[4]



[4] https://www.diabetes.org.uk/professionals/position-statements-reports/diagnosis-ongoing-management-monitoring/end-of-life-care

10 References

This guideline has been adapted from:

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Appendix A - Tips for Prescribing at the End of Life

CARING FOR YOU

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10 Tips for Prescribing at the End of Life

Every patient is different

What works for one might not work for another

Discussion

Make medications part of your discussion with the patient and their family so that everyone understands the decisions that are made.

Necessity

Consider what medications are needed. Those intended for long term risk reduction (e.g. statins) are unlikely to be of benefit any longer. Those that may give symptomatic relief (e.g.regular pain relief, laxatives, PPIs, anti-anginals may still be appropriate if patient is able to take them.

Route

Is your patient able to swallow? If they are able and happy to take medications orally, those that may still benefit from can be continued. If not, SC is usually the most appropriate. Avoid IV or IM medication where possible.

Dose

Patients who are opiate naïve or with renal impairment will need lower doses than those who have already been taking opiates. Think about frailty in older patients.

Anticipatory

Remember to prescribe PRN anticipatory medications for pain, agitation, nausea and secretions. Just because a patient isn't having these symptoms now doesn't mean they won't in the future! Check historic renal function and use renal prescribing guidelines if eGFR <30.

Review and Plan

Regular review of medications and routes. Things may need to be stopped or route changed if patient becomes too drowsy to take tablets. Make sure there is a clear plan from parent team for medications if patient is likely to deteriorate out of hours.

Syringe Driver

Consider starting a syringe driver when the patient experiences persistent or intractable symptoms. This can be commenced prior to the need for stat doses.

Mouth Care

Remember that oral balance gel is something that needs prescribing and can give a lot of symptomatic relief.

Documentation

Make sure documentation of discussions with patients and relatives, decisions and future plans are clear in the notes. Useful for those caring for patients out of hours.

Discharge

When discharging patients don't forget to fill in the yellow discharge paperwork (CD1 form) for anticipatory medications.

For more information see the End of Life Care Guidelines via the Junior Doctors Portal on the intranet
For urgent advice contact the specialist palliative care team via bleep 3010 in hours or St Barnabas OOH via Switch

Appendix B - Medication Table from Lincolnshire CD1 Form (Direction to Administer Drugs for Symptom Management)

PRESCRIBING GUIDELINES

The information within these guidelines is referenced to & should be used in conjunction with Palliative Care Formulary (PCF) 8, Palliative Care Adult Network Guidelines, Scottish Palliative Care Guidelines & the British National Formulary.

Prescribing responsibility remains with the prescriber.
Maximum doses may be extended and some maximum doses only to be used **following discussion** with a Specialist Palliative Care Clinician. Be aware of drug accumulation in **renal failure** and seek guidance below for alternative analgesia.

Please note that only Morphine, Diamorphine, Oxycodone and Levomepromazine are licensed for subcutaneous use. It is accepted practice in palliative care to administer other appropriate drugs via the subcutaneous route.
It is recommended that **no more than 3 drugs** are combined in one syringe unless advised by the Specialist Palliative Care Team. Drug compatibility information can be freely accessed in the PCF8 and **book.pallcare.info** . Otherwise, seek specialist advice.

Match oral / SC / Syringe driver medication i.e. oxycodone prn - oxycodone in syringe driver.
PRN doses may vary according to the need of the individual patient.
PRN doses will need titration in line with regular analgesia dose adjustments.

Symptom/Medication	PRN	Syringe Driver	Max Doses
Pain/Breathlessness			
Morphine	2.5mg – 5mg 2 hourly OR 1/6th of daily syringe driver dose, 2 hourly	If opioid naïve usual starting dose 5mg. Calculate previous 24 hours total oral morphine dose and divide by 2.	
Diamorphine *Useful if large doses of morphine required (PRN or syringe driver)*	2.5mg – 5mg 2 hourly OR 1/6th of daily syringe driver dose, 2 hourly	Calculate previous 24 hours total oral morphine dose and divide by 3. (More potent than morphine)	
Oxycodone	2.5mg – 5mg 2 hourly OR 1/6th of daily syringe driver dose, 2 hourly	Calculate previous 24 hours oral oxycodone and divide by 2. *NB not compatible with cyclizine*.	
Alfentanil *(If eGFR <30 - use if available. Otherwise use oxycodone with caution – reduce dose and frequency).*	125micrograms hourly OR 1/6th of daily syringe driver dose, hourly	If opioid naïve usual starting dose 500 micrograms. Calculate equivalent SC dose of diamorphine and divide by 10.	
Anti-spasmodic/obstruction (If obstruction please seek specialist advice)			
Hyoscine Butylbromide	20mg 2 hourly PRN	60mg	120mg
Nausea & Vomiting			
Levomepromazine *Dilute with water for injection. However, if site reacts, try 0.9% sodium chloride.*	3.125mg – 12.5mg 2 hourly PRN	6.25mg – 25mg	50mg
Haloperidol	500 micrograms – 3mg 2 hourly PRN	1.5mg	10mg
Metoclopramide	10mg 2 hourly PRN	30mg – 60 mg	100mg
Cyclizine *Dilute well to prevent crystallization and/or site reactions. Can **only** use water for injection as diluent.*	25mg 8 hourly PRN	50 – 75mg	75mg
Confusion/Agitation/Delirium			
Midazolam *Can also be used 2nd line for breathlessness.*	2.5mg – 5mg 2 hourly PRN	5mg – 30mg	60mg (100mg*) ****(under specialist advice only)***
Levomepromazine	3.125mg – 12.5mg 2 hourly PRN	6.25mg – 50mg *Consider sedating effect if used in higher doses.*	150mg (250mg*) ****(under specialist advice only)***
Respiratory Secretions			
Hyoscine Butylbromide *If PRN is effective, consider commencing syringe driver.*	20mg 2 hourly PRN	40mg – 100mg	120mg
Epilepsy/Seizure			
Midazolam	10mg/2ml for seizure (>5min), can repeat after 10 min.	20mg when unable to swallow anti-epileptic medication or no IV access (seek specialist advice).	Seek specialist advice if the seizure does not respond after 2 doses.
Terminal Crisis Event Eg significant distressing bleed		**If any potential for terminal crisis event seek specialist advice. Consider buccal midazolam 10mg/1ml as per end of life bleed guidance.**	

If symptoms do not respond, please seek early advice. Contact a Macmillan Specialist Palliative Care Nurse OR St Barnabas Hospice (01522 511566) OR Thorpe Hall Hospice (01733 225900)

Appendix C - Controlled Drug Prescribing & Guide to Equivalent Doses for Opioid Drugs

Pharmacy

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Controlled Drug Prescribing & Guide to Equivalent Doses for Opioid Drugs

All healthcare professionals prescribing, dispensing or administering opioid medicines must ensure they take the necessary steps to prevent patients receiving unsafe doses.
This includes:

- Confirming any recent opioid (dose, formulation, frequency of administration) and any other analgesic medicines prescribed for the patient
- Ensure where a dose increase is intended, that the calculated dose is safe for the patient
- Check the usual starting dose, frequency of administration, standard dosing increments, symptoms of overdose and common side effects of that medicine and formulation

Prescribing Controlled Drugs

A pharmacist is not allowed to dispense a Controlled Drug unless all the information required by law is given on the prescription.
All of the following are required for the legal supply of Controlled Drugs on discharge from the hospital or for the supply to Outpatients.

- The original prescription must be presented to pharmacy. Faxed and photocopied prescriptions are deemed illegal.
- The prescription must be written in indelible ink. Only the signature needs to be handwritten by the prescriber. All other details, including the date can be computer generated.

In general prescriptions for Controlled Drugs should be limited to a supply of up to 30 days and a prescription for a Controlled Drug is valid for 28 days from the date stated.

Prescriptions for Controlled Drugs are subject to prescription requirements.
A prescription for controlled drugs must include :

- Patient's full name, address and NHS number
- Age of patient (if under 12)
- Name of drug
- Form of drug (even if only one form exists)
- Strength of preparation where applicable
- Dose to be taken
- Total quantity required in both words and figures
- For liquids the total volume in millilitres in both words and figures
- Prescriber signature
- Print name and date on prescription

This table is to be used as a guide rather than a set of definitive equivalences. **Please seek specialist palliative care advice before switching from one type of opioid medication to another.**

Transdermal buprenorphine		Transdermal fentanyl	Oral codeine	Oral morphine			Subcutaneous morphine		Subcutaneous diamorphine		Oral oxycodone			Subcutaneous oxycodone		Subcutaneous alfentanil		Subcutaneous fentanyl	
Transtec Patch (microgram/hr)	BuTrans Patch (microgram/hr)	Patch strength (microgram/ hr)	24h Total dose (mg)	4hr dose (mg)	12hr MR dose (mg)	24hr Total dose (mg)	4hr dose (mg)	24hr Total dose (mg)	4hr dose (mg)	24hr Total dose (mg)	4hr dose (mg)	12hr MR dose (mg)	24hr Total dose (mg)	4hr dose (mg)	24hr Total dose (mg)	4hr dose (mg)	24hr Total dose (mg)	4hr dose (microgram)	24hr Total dose (microgram)
	5		<60			10													
	10		60-120			20													
	20	12	120	5	15	30	2.5	15	1.25	10	2.5	7.5	15	1.25	7.5	0.125	1	25	200
35		25		10	30	60	5	30	2.5-5	20	5	15	30	2.5	15	0.25	1.5	50	300
35		25		15	45	90	7.5	45	5	30	7.5	25	50	3.75	25	0.5	3	100	600
52.5		37		20	60	120	10	60	7.5	40	10	30	60	5	30	0.75	4		
70		50		30	90	180	15	90	10	60	15	45	90	7.5	45	1	6		
		75		40	120	240	20	120	12.5	80	20	60	120	10	60	1.25	8		
		75		50	150	300	25	150	15	100	25	75	150	12.5	75	1.5	10		
		100		60	180	360	30	180	20	120	30	90	180	15	90	2	12		
		125		70	210	420	35	210	25	140	35	105	210	17.5	100	2.5	14	Syringe pump volume issues likely above 500micrograms/24hours	
		125		80	240	480	40	240	27.5	160	40	120	240	20	120	2.5	16		
		150		90	270	540	45	270	30	180	45	135	270	22.5*	135	3	18		
		150		100	300	600	50	300	35	200	50	150	300	25*	150	3.5	20		
		175		110	330	660	55	330	37.5	220	55	165	330	27.5*	165	3.75	22		
		200		120	360	720	60	360	40	240	60	180	360	30*	180	4	24		

*This dose requires using 50mg/1ml injection as it would otherwise be too large a volume for a SC injection. **Caution with this strength.**

References:
National Reporting & Learning System (NRLS) Reducing Dosing Errors with Opioids, July 2008. Available online: http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59888
A Guide to Equivalent Doses for Opioid Drugs – St. Christopher's Hospice 2010
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PCF6 – accessed via palliativedrugs.com on 3.1.18
What are the equivalent doses of oral morphine to other oral opioids when used as analgesics in adult palliative care? Medicines Q&As (UKMi). September 2016. Available through NICE Evidence Search at www.evidence.nhs.uk

Updated Dr K Collett – Palliative medicine consultant (ULHT Specialist Palliative Care Team and St Barnabas Hospice) – January 2018. Original author: Sarah Rice – Medicine Optimisation and Safety Lead – Pharmacy – October 2015

ULHT/G/2018/013G CESC Approved March 2018 Reviewed: March 2024

Appendix D - MND Guidance for the Management of Symptoms at End of Life

Appendix E - Use of Alfentanil in Renal Failure in Palliative Care

Use of Alfentanil in Renal Failure in Palliative Care in Lincolnshire

Introduction

This information sheet is intended as a resource for staff in Lincolnshire looking after palliative care patients who have been prescribed Alfentanil for pain relief. It is not a clinical guideline.

Most opioids are renally excreted and can accumulate in renal failure. Some patients with poor renal function can tolerate commonly used opioids such as morphine or oxycodone. Others develop significant side effects such as confusion, drowsiness, hallucinations and myoclonus (twitching).

Alfentanil is an alternative opioid that can be used for pain relief in a syringe driver for patients with poor renal function in the last few days of life.

This guidance should make prescribing this more straightforward. If in doubt seek specialist advice by ringing St Barnabas In-Patient Unit on 0300 303 1754 or Thorpe Hall on 01733 225900 at any time.

What is Alfentanil?

Alfentanil is a synthetic strong opioid. Compared to parenteral morphine it is more potent, works more quickly but has a shorter duration of action. Alfentanil is licensed for IV use as an analgesic during surgery or in ITU. It is metabolised by the liver to inactive metabolites that are excreted in the urine.

When is it used in palliative care?

Sub-cutaneous (SC) Alfentanil is used by palliative care clinicians in situations where patients are struggling with side effects from opioids due to significant renal failure. It is usually given via continuous SC infusion with a syringe driver to provide background analgesia.

SC Alfentanil can be used as a breakthrough (PRN) analgesic but its short duration of action may mean that it does not provide an adequate length of pain relief. It can be used for short lived incident related pain e.g., dressing changes. Trans mucosal fentanyl products (licensed for breakthrough pain) are now more commonly used for this indication.

How do I use it?

It can be appropriate for patients to try or continue alternative opioids, especially if they are still taking oral medications. The doses and frequency of administration of alternative opioids may need to be reduced to account for the reduced renal excretion. Monitoring for adverse effects is required.

Consider alfentanil for opioid analgesia in patients with an eGFR <30 or when the patient is known/likely to have significantly deteriorating renal function. If considering use before a patient is thought to be in the last days of life, the pros and cons of syringe driver use should be discussed. E.g., impact on mobility, showering. Continuous SC infusions are normally used in palliative patients who are unable to manage oral medication due to nausea and vomiting or swallowing problems.

For opioid naïve patients the usual starting doses are:

Continuous SC infusion via syringe driver - 500micrograms/24 hours.
PRN – 125 micrograms SC. Can be repeated hourly.

For patients who are already on opioids, the alfentanil dose will be based on their previous opioid requirements (table 1).

Approximate 24 hour equivalent doses to 30mg/24 hours oral morphine			
Oral morphine	SC morphine	SC diamorphine	SC alfentanil
30mg	15mg	10mg	1mg
	Divide oral morphine dose by 2	Divide oral morphine dose by 3	Divide oral morphine dose by 30

For the breakthrough/PRN dose divide the 24 hour dose by 6. This can be repeated up to hourly. Ranges can be used in the same way as other opioids. Administer lower doses first and titrate up if required.

How do I prescribe it?

Alfentanil is a controlled drug that comes in several strengths. The most appropriate for use in palliative care is 2ml ampoules of Alfentanil 500microgram/ml.

In a syringe driver, alfentanil is compatible with other commonly prescribed symptom control medications of midazolam, levomepromazine and hyoscine butylbromide. It can be diluted with water for injection or normal saline.

What is needed?

Whenever a patient is transferred from one strong opioid to another, they should be monitored for signs of being:

- under-opiated – i.e. increased pain
- over-opiated e.g., drowsiness, confusion, respiratory depression

For patients with ongoing pain, titrate alfentanil in the same way as other opioids. An increase of 25-50% at a time is commonly recommended. For patients that appear over-opiated, consider reducing the opioid dose. Be aware that these signs may be irreversible signs of a patient who is close to death.

Cautions to note:

Contra-indications: Do not administer concurrently with MAOIs or within two weeks of their discontinuation. Generally, no absolute contra-indication if titrated carefully against a patient's pain.

Alfentanil can accumulate where hepatic clearance is reduced e.g., the elderly or a patient with hepatic impairment. Consider using smaller doses overall and use conservative dose estimates when converting from other opioids.

Opioid withdrawal symptoms can occur when switching from morphine or oxycodone to a continuous SC infusion of alfentanil. These manifest with symptoms like gastric flu and last for a few days; PRN doses of the original opioid will relieve troublesome symptoms.

Alfentanil is metabolised in the liver by CYP3A4. Caution is required with concurrent use of drugs which inhibit or induce these enzymes. This is not usually an issue for patients who are only on medications for symptomatic control.

K Collett (Consultant in Palliative Medicine)
St Barnabas Hospice and ULHT

References (last accessed 6.11.17):

Alfentanil. PCF6 accessed via www.palliativedrugs.com/Alfentanil, St Elizabeth Hospice, Ipswich.

Available at: **https://www.stelizabethhospice.org.uk/clinical-guideline/analgesic-use-in-renal-failure/ [Accessed on December 27th 2023].**

Appendix F - List of Abbreviations

List of Abbreviations	
SC	Sub cutaneous
SOB	Shortness of breath
N + V	Nausea and vomiting
H/hrly	Hourly
mg	Milligram
PRN	As needed
ULHT	United Lincolnshire Hospitals Trust
LCHS	Lincolnshire Community Health Services
JIC	Just in case
eGFR	Estimated glomerular filtration rate
PO	By mouth
PR	By rectum
CSCI	Continuous sub cutaneous infusion
TDS	Three times daily
PO/IV	Per oral/intravenous
MHRA	Medicines and Healthcare Products Regulatory Agency
CHM	Commission on Human Medicines
ACKD	Advanced chronic kidney disease
ml	Millilitre
mmol	Millimole
BM	Capillary glucose monitoring
NICE	National Institute of Clinical Excellence

Appendix G - Quality and Equity Impact Assessment Symptom Management

This tool has been developed by the Equality, Diversity and Inclusion Leads for use in the NHS Provider organisations in Lincolnshire. The tool is designed to ensure due regard is demonstrated to the Equality Act 2010, the Public Sector Equality Duty and potential health inequalities are also identified and addressed (as outlined in the Health and Social Care Act). Please complete all sections below. Instructions are in **bold** Email for all correspondence: email to lhnt.edifirst@nhs.net.

Service or Workforce Activity Details

Description of activity	The purpose of the Lincolnshire Symptom Management in Adult Palliative and End of Life Care guidance to facilitate a consistent evidence-based approach and person-centered care planning for across all providers of adult palliative and end of life care in Lincolnshire.
Type of change	Adjust existing guidance
Form completed by	Elaine Wilkins Advanced Clinical Practitioner in Palliative care, Macmillan LCHS.
Date decision discussed & agreed	15/04/2024
Who is this likely to affect?	Service users X Staff X Wider Community □ If you have ticked one or more of the above, please detail in section B1, in what manner you believe they will be affected.

Equality Impact Assessment

(Below must be normal)

Complete the following to show equality impact assessment considerations of the decision making to ensure equity of access and to eliminate harm or discrimination for any of the protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation. Further, please consider other population groups which are at risk of health inequality and can include, but not be limited to, people who are; living in poverty/ deprivation, geographically isolated (e.g. rural), carers, armed forces, migrants, homeless, asylum seekers/refugees, surviving abuse, in stigmatised occupations (e.g. sex workers), use substances etc.

Please ensure you consider the connections (intersectionality) between the protected characteristics and population groups at risk of health inequality (e.g. it is recognised that older men from a BAME background, with one or more comorbidities and living in deprivation are more at risk of a poorer outcome if they contract CV-19).

(Below must be table paragraph)

How does this activity/decision impact on protected or vulnerable groups? (e. g. their ability to access services/ employment and understand any changes?) Please ensure you capture expected positive and negative impacts.	This guidance has been co-designed with a multiagency approach to ensure optimise equity of timely access to safe prescribing and medications for adults who are registered with a Lincolnshire GP. The language has been reviewed to remove and perceived ambiguity to support timely clinical decision making with a person-centered approach across all providers including patients requiring mental health care. It is expected that these amendments will impact positively on improved timely access to symptom management through the improved timely use of continuous subcutaneous infusion.
What data has been/do you need to consider as part of this assessment? What is this showing/telling you?	e.g. Patient data/workforce data/population data/JSNA data etc, broken down by protected characteristics and groups at risk of health inequality. Themes identified through incident reporting investigations and published research have been used to inform the amendments to this policy.

Risks and Mitigations

What actions can be taken to reduce/mitigate any negative impacts? (If none, please state.)	Education lead by palliative care teams within organisations will be used to raise awareness of this guidance
What data/information do you have to monitor the impact of the decision?	Datix incident reporting will continue to be used to identify any issues or concerns. These will be reported into the Lincolnshire PEOLC Programme Quality Forum. The PEOL Programme also has a monthly operational group meeting where issues can be raised.

Decision/Accountable Persons

Endorsement to proceed?	Yes
Any further actions required?	**eg. risk to be added to the risk register or capturing in local action log etc.** No
Name & job title accountable decision makers	Responsibility for Guidance – Lincolnshire PEOL oversite Elaine Wilkins - Advanced Clinical Practitioner in Palliative Care
Date of decision	15/04/2024
Date for review	**Please note: the equality impact assessment is a 'live' document and must be reviewed regularly/when any significant change occurs.** April 2026

Purpose of the Equality and Health Inequality Assessment tool

- The NHS in Lincolnshire has a legal duties under the Equality Act 2010, Public Sector Equality Duty 2011 and the Health and Social Care Act 2012 to demonstrate due regard in all decision making, for example, when making changes to services or workforce practices, to ensure access to services and workforce opportunities are equitable and to avoid harm and eliminate discrimination for each of the protected characteristics and other groups at risk of inequality.
- Within the guidance toolkit there are also some examples of decisions this tool has been used on in other organisations and the impacts they have identified.

Review of document

Two yearly

Checklist

- Is the purpose of the policy change/decision clearly set out? Yes
- Have those affected by the policy/decision been involved? Yes
- Have potential positive and negative impacts been identified? No
- Are there plans to alleviate any negative impact? Yes
- Are there plans to monitor the actual impact of the proposal? Yes