

'Just in Case 4 Core Drugs' for the End of Life

Indication for Use

One of the major causes of distress in the last days of life occurs when patients can no longer swallow their oral medication and there is a delay in accessing the appropriate parenteral medication. In many instances, the symptoms that occur are ones that could have been anticipated and planned for.

Examples include:

- A patient has pain that was well controlled on oral medication, deteriorates and is unable to swallow their usual medication.
- A patient has end stage respiratory disease, becomes weaker and develops troublesome respiratory secretions because they cannot cough.

Using knowledge of the disease along with common potential problems, the doctor is able to safely prescribe drugs in anticipation and authorise their administration by the appropriately trained nurses.

End of life drugs

Principles:

- Only use **injectable** forms of the drug as most patients lose their ability to swallow safely at the end of life.
- Always give **stat doses subcutaneously**.
- Set up a continuous sc infusion (CSCI) using a syringe driver if the patient has required 2 or more stat injections. When commencing a CSCI for the first time, it will take at least 4 hours to reach a steady state, so it is important to cover the intervening period of time by giving appropriate stat doses simultaneously.
- Always ensure there is enough medication to make up 48 hours of syringes; more if a bank holiday is approaching.
- Ensure that a member of the healthcare team reviews the patient on at least a daily basis to ensure symptoms remain controlled.
- Always ensure there are **appropriate breakthrough doses** of medication available and prescribed to cover the common symptoms listed below.
- The drugs, doses and PRN frequencies recommended are the **starting** doses for **first line** JIC4CD end of life anticipatory medications. Different drugs may be prescribed if they are intolerant of these recommended first line medications, or if they are discharged from University Hospitals of Morecambe Bay NHS Foundation Trust. Higher starting doses and/or PRN drugs can be used if assessed as clinically appropriate. Doses should be titrated up if symptoms persist.
- The Specialist Palliative Care Service is available to be contacted for advice whenever necessary.

Specialist Palliative Care Advice Line for Health Professionals

- **For Blackpool, Fylde & Wyre** Trinity Hospice, Blackpool
01253 359359 (24 hours)
- **for Lancaster, Morecambe & Carnforth** St John's Hospice, Lancaster
01524 382538

For Pain

It is unusual for patients to develop a new set of pains at the end of life. However, it is common for pre-existing pain to be more troublesome, and for patients to become stiff exacerbating muscular-skeletal pain.

Use Diamorphine

In a opioid naïve patient

- Prescribe diamorphine 2.5-5mg SC stat injection 1 hourly PRN for breakthrough pain.
- Consider commencing diamorphine 10-20mg over 24 hours via a CSCI using a syringe driver if symptomatic.
- If the patient is very frail, or there is a concern about renal failure, use diamorphine 2.5mg SC stat and a starting dose of diamorphine 5mg over 24 hours via a CSCI. Consider discussing such patients with the specialist palliative care team.

If the patient is already on opioids

- Convert current dose of daily oral morphine to diamorphine SC by dividing by 3, and prescribe this dose of diamorphine over 24 hours via a CSCI.
- Ensure breakthrough analgesia prescribed e.g. 1/6 total daily dose diamorphine SC stat 1 hourly PRN.

If the patient is on a buprenorphine patch or fentanyl patch

- Leave the patch in situ and change as usual
- Discuss with the Specialist Palliative Care Service for advice regarding further analgesia.

Always discuss with the Specialist Palliative Care Service if you are unsure, or the dose of diamorphine exceeds 100 mg over 24 hours.

For Nausea and Vomiting

Use Levomepromazine

- Prescribe PRN antiemetic of levomepromazine 6.25mg SC stat injection 8 hourly PRN.
- Consider commencing levomepromazine 6.25-12.5mg over 24 hours via a CSCI using a syringe driver if symptomatic.
- ***If the symptoms are not controlled on levomepromazine 25mg over 24 hours, contact the Specialist Palliative Care Service for advice.***

For Agitation and Terminal Restlessness

Always check to see if the patient is in urinary retention or if constipation is a problem. If appropriate, this should be managed before medications are introduced or altered. If the patient is a smoker, consider nicotine replacement therapy.

Use Midazolam

- Prescribe PRN anxiolytic of midazolam 2.5-5 mg SC stat injection 4 hourly PRN.
- Consider commencing midazolam 10-20mg over 24 hours via a CSCI using a syringe driver if symptomatic.
- Maximum recommended dose is 60mg over 24 hours.
- ***If patient remains restless on midazolam 30mg over 24 hours, contact the Specialist Palliative Care Service for advice.***

For Respiratory Tract Secretions

Use Glycopyrronium

- Prescribe PRN antisecretory of glycopyrronium 0.2mg SC stat injection 4 hourly PRN.
- And, concurrently, commence glycopyrronium 0.6-1.2mg over 24 hours via a CSCI using a syringe driver.
- Maximum dose is 1.2mg over 24 hours.
- ***If secretions are not settling, contact the Specialist Palliative Care Service for advice.***