Palliative and End of Life Care
One Gloucestershire

One Gloucestershire
Transforming Care, Transforming Communities

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 key points of good end of life care are:

- End of life care should be person-centred.
- Follow national and local guidelines for caring for people at end of life.
- Communication between staff and the dying person should be sensitive, clear and timely.
- Involve the dying person and those important to them in decisions about their care.
- Identify, and meet, each person's physical, psychological, social and spiritual needs.
- Meeting a person's needs may require many members of the multidisciplinary team.
- Offer support to the dying person's family, carers and others important to them.
- Caring for someone at the end of their life can be distressing. Look after your own wellbeing and ask for help and support if you need it.

SYMPTOM	USUAL "AS REQUIRED" (PRN) STARTING DOSE	STARTING DOSE FOR SYRINGE PUMP IF NEEDED (Consider if 2 or more PRN doses needed in last 24hrs)
PAIN / TACHYPNOEA	Must be individualised see algorithm opposite	
NAUSEA	Levomepromazine 6.25mg s/c 6 hrly	Levomepromazine 6.25mg s/c over 24 hours * *Due to long half life drug single daily injection often adequate.
AGITATION / DISTRESS	Midazolam 2.5-5mg s/c every 60 mins until settled.	Midazolam 5-10mg s/c over 24hrs
SECRETIONS (Review parenteral fluids)	Glycopyrronium 200-400 mcg s/c 2-4hrly	Glycopyrronium 600-1200mcg s/c over 24 hrs

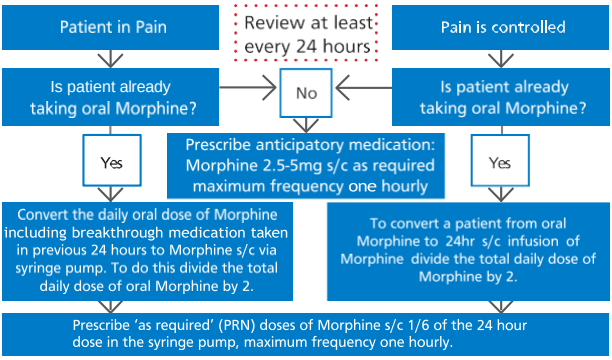
For palliative care advice

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



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 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.

Strategy for breaking bad news using the SPIKES model.

S	Setting
P	Perception of condition/seriousness
I	Invitation from the patient to give information
K	Knowledge: giving medical facts
E	Explore emotions and sympathize
S	Strategy and summary