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

Policy Number: DC020

Issue Date: October 2014

Review date: October 2016

Policy Owner: Head Community Services

Monitor: Clinical Risk Group

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.

Trinity Hospice: 0207 787 1000

Adapted with permission from the Guys & St Thomas’ NHS Foundation Trust clinical guideline - End of life symptom control guidelines for adult inpatients with renal failure (eGFR < 30 mL/ min)
### 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

### Policy Profile

<table>
<thead>
<tr>
<th>Author:</th>
<th>Target Audience:</th>
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<tbody>
<tr>
<td>Dr Sam Lund, Dr Sarah Cox, Dr Stephen Deas GP, Annabelle May CNS, Helen Brewerton CNS, Steven Wanklyn Consultant Pharmacist, Cathy Maylin Community Services Manager.</td>
<td>TH Community Team TH Inpatient Unit GP’s &amp; DN’s</td>
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| Individuals/Groups consulted | Medical Lead Community Services; Medical Director; Community Nursing Team; Pharmacy Lead. |

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<th>Approval:</th>
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<tr>
<td>Clinical Risk Management Group</td>
<td>Clinical Governance Committee (via email)</td>
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### Document History

<table>
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<tr>
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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:**

Morphine 5 – 10 mg subcutaneous infusion to run over 24 hours via a syringe pump
Morphine 2.5 – 5 mg subcut 1-hourly PRN

**Symptoms appear**

Consider place of care and practical issues

**Administer medications in one of two ways:**

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Maintain PRN dosing as above
Less frequent dosing will be needed as symptoms become controlled
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Anticipatory Prescribing – ahead of symptoms appearing or worsening:

Morphine 5 – 10 mg subcutaneous infusion to run over 24 hours via a syringe pump
Morphine 2.5 – 5 mg subcut 1-hourly PRN

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| Set up a subcutaneous infusion of Morphine to run over 24 hours via a syringe pump: |
| Morphine 5 – 10 mg/ 24 hours |
| Monitor symptoms |
| Review need and seek advice if symptoms remain uncontrolled |
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.
  - Anxiety and/or confusion.

- For patients already on an analgesic preparation, including another opioid, seek advice from the Palliative Care Team.

- Consider using subcutaneous Morphine 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 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

- 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 12 hours 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 10 – 30 mg subcutaneous infusion to run over 24 hours via a syringe pump
Midazolam 2.5 mg subcut 1-hourly PRN

**Symptoms appear**
**Consider place of care and practical issues**
**Administer medications in one of two ways:**

1. **Midazolam 2.5 mg 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**

2. **Midazolam 2.5 mg subcut immediately**
   - Monitor symptoms
   - Symptoms remain uncontrolled after 60 minutes
   - **Administer a 2nd dose of Midazolam 2.5 mg subcut**
   - Monitor symptoms
   - If symptoms remain uncontrolled
     - **Seek advice** and consider:

   **Set up a subcutaneous infusion of Midazolam to run over 24 hours via a syringe pump:**
   Midazolam 10 – 30 mg/ 24 hours
   - Titrate the dose in the syringe pump according to clinical situation and PRN dose requirements:
     - Midazolam 2.5 mg subcut 1-hourly PRN
   - Monitor symptoms
   - **Review need and seek advice if symptoms remain uncontrolled**
Supporting information

- Explain to the patient if possible, the patient’s carer(s)/family what might be causing the symptoms and that it is not likely to distress the patient if they are unconscious.

- Eliminate potentially reversible causes, in particular pain and discomfort that may be caused by a full bladder or rectum.

- If it is necessary to consider sedation this should be discussed with the patient, if possible, and their carer(s)/family.

- 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)
- 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 2.5mg -5 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:

Haloperidol 1.5 mg 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

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

Symptoms remain uncontrolled after 60 minutes
Administer a 2nd dose of Haloperidol 1.5 mg subcut
Monitor symptoms
If symptoms remain uncontrolled
Seek advice and consider:
Set up a subcutaneous infusion of Haloperidol to run over 24 hours via a syringe pump:
Haloperidol 2.5 – 5mg / 24 hours
Titrate the dose in the syringe pump according to clinical situation and PRN dose requirements:
Haloperidol 1.5 mg subcut 1-hourly PRN
Monitor symptoms
Review need and seek advice if symptoms remain uncontrolled
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 or infection.
  - 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 and/ or confusion.

- Consider using **subcutaneous Haloperidol** 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 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.
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**RESPIRATORY TRACT SECRETIONS**

**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:
- Hyoscine Butylbromide (Buscopan) 20 mg subcut 1-hourly PRN
- Hyoscine Butylbromide 60 mg subcutaneous infusion to run over 24 hours via a syringe pump

- **Symptoms appear**
  - **Consider place of care and practical issues**
  - **Administer medications in one of two ways:**

  **Hyoscine Butylbromide 20 mg 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**

  **Hyoscine Butylbromide 20 mg subcut immediately**
  - Monitor symptoms
  - **Symptoms remain uncontrolled after 60 minutes**
  - **Administer a 2nd subcut dose of Hyoscine Butylbromide 20 mg**
  - **Monitor symptoms**
  - If symptoms remain uncontrolled
  - **Seek advice** and consider:

  **Maintain PRN dosing as above**
  - Less frequent dosing will be needed as symptoms become controlled
  - **Monitor symptoms**
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  **Set up a subcutaneous infusion of Hyoscine Butylbromide to run over 24 hours via a syringe pump:**
  - **Hyoscine Butylbromide (Buscopan) 60 mg / 24 hours**
  - **Titrate the dose in the syringe pump according to clinical situation and PRN dose requirements:**
  - **Hyoscine Butylbromide 20 mg subcut 1-hourly PRN**
  - **Monitor symptoms**
  - **Review need and seek advice if symptoms remain uncontrolled**
Supporting information

- This symptom is due to aspirated oropharyngeal secretions and retained bronchial secretions, although in some patients there may be underlying infection.

- 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. If infection is present 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:
  - 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.