Guidelines: EOLC Symptom Control for Patients with Renal Failure (in Wandsworth & Tri-borough)

Policy Number: C018

Issue Date: October 2014
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Policy Owner: Head Community Services
Monitor: Clinical Risk Group

Renal Function (eGFR < 30 mL/ min)

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.

This guidance is designed for internal use only at Royal Trinity Hospice as a prompt for advice.

External sharing on a named patient basis only
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

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<tr>
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<td><strong>Target Audience:</strong> TH Community Team, TH Inpatient Unit</td>
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| Individuals/ Groups consulted |
| Medical Lead Community Services; Medical Director; Community Nursing Team; Pharmacy Lead. |

| Approval: |
| Clinical Risk Management Group |
| Date: July ‘14 |

| Ratification: |
| Clinical Governance Committee (via email) |
| Date: July ‘14 |

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End of life symptom control guidelines for adult patients with Renal Failure (eGFR < 30 mL/min)

**Pain**

- For patients already on an analgesic preparation, including another opioid, or symptoms remain uncontrolled seek advice from the Specialist Palliative Care Team at Royal Trinity Hospice.
- Explain to the patient and/or carer(s)/ family what may be causing the pain.
- Consider non-medication interventions that may help relieve pain e.g. re-positioning if appropriate.
- Eliminate potentially reversible causes that may be exacerbating symptoms: consider infection and/or inflammation, signs suggestive of obstruction or constipation, anxiety.
- Consider using Alfentanil subcutaneously following the dosing schedule below.
- In practice, after the first 2 – 3 PRN doses, it would be uncommon for them to be given so frequently.

### Nausea and vomiting

#### Symptoms appear

- **Alfentanil subcut immediately**

#### Symptoms controlled

- Maintain PRN dosing
- Monitor symptoms

#### Symptoms remain uncontrolled

- **Seek advice** and consider setting up a subcut infusion to run over 24 hours via a syringe pump:
  - Alfentanil 500-1000 microgram/24 hours subcut
  - **Consider alfentanil 250-500 micrograms/24 hours sc for the frail/elderly**
- Monitor symptoms and titrate the dose in the syringe pump according to clinical situation and PRN dose requirements

#### Symptoms recur within 24 hours

- Administer a 2nd dose of Alfentanil subcut

#### Symptoms not controlled after 30 minutes

- Maintain PRN dosing
- Monitor symptoms and titrate the dose in the syringe pump according to clinical situation and PRN dose requirements
Explain to the patient and/or carer(s)/ family what may be causing the symptoms.

Eliminate potentially reversible causes that may be exacerbating symptoms: consider other medications, severe pain, biochemical factors (e.g. hypercalcaemia and/or signs of dehydration), infection, raised intra-cerebral pressure, oral problems, anxiety, obstruction or constipation.

Consider current medications that are controlling symptoms and could be continued by the subcut route.

Consider using **Haloperidol OR Levomepromazine** subcutaneously following the dosing schedules below.

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

If symptoms remain uncontrolled or if you need advice contact the Specialist Palliative Care Team at Royal Trinity Hospice.

Anticipate symptoms and prescribe in advance on the Drug Authorisation chart:

- Haloperidol 0.5 mg subcut up to 1-hourly PRN
- **OR** Levomepromazine 3.125 mg subcut up to 1-hourly PRN

- **Symptoms appear**
  - Haloperidol 0.5 mg subcut
  - **OR** Levomepromazine 3.125 mg subcut immediately

- **Symptoms controlled**
  - Maintain PRN dosing
  - Monitor symptoms

- **Symptoms not controlled after 60 minutes**
  - **Seek advice** and consider setting up a subcut infusion to run over 24 hours via a syringe pump:
    - Haloperidol 1.5 mg/24 hours subcut
    - **OR** Levomepromazine 6.25 mg/24 hours subcut
    - Maintain PRN dosing
    - Monitor symptoms and titrate the dose in the syringe pump according to clinical situation and PRN dose requirements

- **Symptoms recur within 24 hours**
  - Administer a 2nd dose of
    - Haloperidol 0.5 mg subcut
    - **OR** Levomepromazine 3.125 mg subcut

- **Symptoms remain uncontrolled**

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End of life symptom control guidelines for adult patients with **Renal Failure** (eGFR < 30 mL/min)

**Agitation and distress**

- Explain to the patient and/or carer(s)/ family what may be causing the symptoms.
- Eliminate potentially reversible causes that may be exacerbating symptoms: consider pain and discomfort that may be caused by a full bladder or rectum.
• Consider using Midazolam subcutaneously following the dosing schedule below.
• In practice, after the first 2 – 3 PRN doses, it would be uncommon for them to be given so frequently.
• Consider adding an antipsychotic e.g. haloperidol or levomepromazine, where the patient shows signs suggestive of delirium or where upward titration of midazolam is not adequately controlling symptoms; seek advice.
• If symptoms remain uncontrolled or if you need advice contact the Specialist Palliative Care Team at Trinity Hospice.

End of life symptom control guidelines for adult patients with Renal Failure (eGFR < 30 mL/ min)

Respiratory tract secretions

- Explain to the patient and/or 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 help stop secretions pooling in the pharynx, reducing the noise. Anticholinergic medications have no effect on secretions that are already present. 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. Medication therapy is effective in about 50% of patients.
- Consider using **Glycopyrronium OR Hyoscine Butylbromide (Buscopan)** subcutaneously following the dosing schedule below.

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

- **If symptoms remain uncontrolled or if you need advice contact the Specialist Palliative Care Team**

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Anticipate symptoms and prescribe in advance on the Drug Authorisation chart:

Glycopyrronium 100 microgram subcut up to 1-hourly PRN
  OR Hyoscine Butylbromide 20mg subcut up to 1-hourly PRN

                                    Symptoms appear
                                    Glycopyrronium 100 microgram subcut
                                    OR Hyoscine Butylbromide 20mg subcut
                                    immediately

                                    Symptoms controlled

                                    Maintain PRN dosing
                                    Monitor symptoms

                                    Symptoms not controlled after 60 minutes
                                    Administer a 2nd dose of
                                    Glycopyrronium 100 microgram subcut
                                    OR Hyoscine Butylbromide 20mg subcut

                                    Symptoms recur within 24 hours

                                    Seek advice and consider setting up a subcut
                                    infusion to run over 24 hours via a syringe pump:
                                    Glycopyrronium 600 microgram/ 24 hours subcut
                                    OR Hyoscine Butylbromide 60-120mg/ 24 hours subcut
                                    Maintain PRN dosing
                                    Monitor symptoms and titrate the dose in the syringe pump according to clinical situation and PRN dose requirements

                                    Symptoms remain uncontrolled
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