End of Life Care

A guidance for health care professionals caring for people in their final days of life
Domains of Issues Associated with Illness and Bereavement

DISEASE MANAGEMENT
Primary diagnosis, prognosis, evidence
Secondary diagnoses (e.g., dementia, psychiatric diagnoses, substance use, trauma)
Co-morbidities (e.g., delirium, seizures, organ failure)
Adverse events (e.g., side effects, toxicity)
Allergies

LOSS, GRIEF
Loss
Grief (e.g., acute, chronic, anticipatory)
Bereavement planning
Mourning

END OF LIFE CARE/DEATH MANAGEMENT
Life closure (e.g., completing business, closing relationships, saying goodbye)
Gift giving (e.g., things, money, organs, thoughts)
Legacy creation
Preparation for expected death
Anticipation and management of physiological changes in the last hours of life
Rites, rituals
Pronouncement, certification
Perideath care of family, handling of the body
Funerals, memorial services,

PHYSICAL
Pain and other symptoms *
Level of consciousness, cognition
Function, safety, aids:
  • Motor (e.g., mobility, swallowing, excretion)
  • Senses (e.g., hearing, sight, smell, taste, touch)
  • Physiologic (e.g., breathing, circulation)
  • Sexual
Fluids, nutrition
Wounds
Habits (e.g., alcohol, smoking)

PSYCHOLOGICAL
Personality, strengths, behaviour, motivation
Depression, anxiety
Emotions (e.g., anger, distress, hopelessness, loneliness)
Fears (e.g., abandonment, burden, death)
Control, dignity, independence
Conflict, guilt, stress, coping responses
Self-image, self-esteem

SOCIAL
Cultural values, beliefs, practices
Relationships, roles with family, friends, community
Isolation, abandonment, reconciliation
Safe, comforting environment
Privacy, intimacy
Routines, rituals, recreation, vocation
Financial resources, expenses
Legal (e.g., powers of attorney for business, for healthcare, advance directives, last will/testament, beneficiaries)
Family caregiver protection
Guardianship, custody issues

PATIENT AND FAMILY
Characteristics
Demographics (e.g., age, gender, race, contact information)
Culture (e.g., ethnicity, language, cuisine)
Personal values, beliefs, practices, strengths
Developmental state, education, literacy
Disabilities

PRACTICAL
Activities of daily living (e.g., personal care, household activities)
Dependents, pets
Telephone access, transportation

SPIRITUAL
Meaning, value
Existential, transcendental
Values, beliefs, practices, affiliations
Spiritual advisors, rites, rituals
Symbols, icons
Supporting Care for the Dying Patient and their Family

Deterioration in the patient’s condition

Is there a potentially reversible cause for the patient’s condition? Exclude: opioid toxicity, renal failure, hypercalcaemia, infection

Could this patient be in the dying phase?

Is referral to Palliative Care Team required? or Second opinion?

Communication with the patient, relative/carer is focused on recognition and understanding that the patient is dying.

Ensure Anticipatory Medication is prescribed

Special Alert Form is completed (community)

Discussion with the patient, relative/carer to explain current plan of care.

Continual regular assessments are carried out.

Any changes in the plan of care are discussed with the patient, relative/carer.

Please refer to Palliative Care Resource File for further guidance.

Specialist Palliative Care Services in the Isle of Man

Author: Cheryl Young, Practice Development Nurse End of Life Care
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Specialist palliative care services offer telephone advice, a single assessment visit or a period of specialist care according to need.

**Referral**
Can be made for an individual who has any life limiting illness, and is in or is entering the end of life phase of their illness, if they have;

- complex end of life care needs.
- uncontrolled pain or other symptoms.
- complex physical, psychological, spiritual or family needs that cannot be met by the staff

A referral should be made by the individual’s G.P. and faxed to Hospice Isle of Man. Individuals must be made aware that a referral has been sent to the CNS Team.

**Palliative Care Clinical Nurse Specialist Team (CNS)**  
Available Monday to Friday 9am-5pm

Hospice Isle of Man  
Tel. 01624 647475 (team office with answerphone)  
01624 647400 (hospice reception)  
Fax: 01624 647460

**Palliative Care out–of–hours**
- Contact Hospice Isle of Man Reception. A senior doctor and/or nurse is available to give telephone advice on complex symptom management.
- Contact Manx Emergency Doctors Service (MEDS) – may need to visit and review individual.
Managing Dying

“How people die remain in the memories of those who live on”
Dame Cicely Saunders

Best Practice
1. The person is enabled to die in the place of their choice. The person is cared for in an environment that promotes dignity, respect and privacy.

2. The family is contacted and advised in a sensitive manner that the person’s condition has deteriorated. They are kept informed and have opportunities to discuss concerns with the team within the home and the wider team members involved in the care.

3. The Consultant/GP and other key health professionals involved in the individual’s care are informed of deterioration in their condition.

4. All members of the multidisciplinary and specialist palliative care teams work together.

Last days of life

Introduction
When all reversible causes for the individual’s deterioration have been considered, the multi-disciplinary team agrees the individual is dying and changes the goals of care.

Reversible causes to consider include
- dehydration
- infection
- opioid toxicity
- renal impairment
- hypercalcaemia
- delirium

Clinical signs may include:
- Person is bedbound
- Increasingly drowsy or semicomatose
- Only able to take sips of fluid
- Difficulty swallowing tablets

Management of a dying individual and their family
- Plan and document care.
- Discuss prognosis (person is dying), goals of care (maintaining comfort) and preferred place of death with the person and/or family.
- If discharge home is possible, prompt and careful planning are needed. Contact GP, District Nurse and Occupational Therapist urgently.
- Clarify resuscitation status; check DNACPR form has been completed. (See: national policy). Reassure the individual and family that full supportive care will continue.
- Discontinue inappropriate interventions (blood tests, IV fluids and medication, vital signs monitoring, frequent blood sugar tests).
- Comfort nursing care (pressure relieving mattress, reposition for comfort only), eye care, mouth care (sips of fluid, oral gel), bladder and bowel care.

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• Explain to the family why the nursing and medical care has been altered and what changes to expect in the individual’s condition. (See leaflet: Preparing for the death of someone for whom you care)
• Record arrangements for contacting the family when the individual deteriorates or dies.
• Community team; ensure the family/ carers know who to contact when the individual dies.
• Consider emotional, spiritual/ religious, legal and family needs including those of children.

Medication – review at least once daily.
• Stop any treatment not needed for symptom control.
• Choose an appropriate route. If able to swallow, consider liquid formulations otherwise change to the subcutaneous or rectal route.
• Consider need for a subcutaneous (SC) infusion of medication via a syringe pump.
• Anticipatory prescribing of ‘as required’ medication in advance for common symptoms.

Hydration
• Over-hydration can contribute to distressing respiratory secretions.
• Artificial fluids are usually not appropriate, but if indicated can be given subcutaneously.
• Discontinue tube feeding/ fluids if respiratory secretions are present, if there is risk of aspiration due to reduced conscious level, or at the individual’s request.

Identify those at increased risk in bereavement and seek additional support.
• Previous multiple losses or recent bereavement
• Ambivalent or dependent relationship
• Living alone and lacking a support network
• Mental illness, drug or alcohol
Anticipatory Prescribing for the Dying Person.

The prescription should include the four medications that might be required for end of life symptom control.

If the individual is already on regular oral opiates or other meds, a syringe pump should be prescribed.

Prescriptions can be written using the following wording:

Analgesic:
**Diamorphine Hydrochloride** injection (5mg ampoules)
Dose: 2.5mg-5mg SC, 2hourly as needed for pain or breathlessness.
Supply 5 (five) 5mg ampoules.

Anxiolytic sedative:
**Midazolam** injection (10mg in 2ml ampoules)
Dose: 2.5mg-5mg SC, 2hourly as needed for anxiety/distress/myoclonus.
Supply 10 (ten) 2ml ampoules.

Anti-secretory:
**Hyoscine Hydrobromide** injection (400mcg/ml ampoules)
Dose: 400mcg SC, 6hourly as needed for respiratory secretions.
Maximum of 2400mcg (2.4mg) in 24 hours via syringe pump
Supply 5 ampoules.

Antiemetic:
**Cyclizine** injection (50mg/ml ampoules)
Dose: 50mg SC, 8 hourly as needed for nausea.
Supply 5 ampoules.

or
**Levomepromazine** injection 25mg/ml
Dose: 6.25mg SC, 6 hourly as needed for nausea.
Supply 5 ampoules.

Dilution
**Water** for injection 10mls
Supply 20 ampoules
### Symptoms

Please also refer to Care of the Dying Guidance (Pages 19-23)

**Pain**

- Paracetamol or Diclofenac (as liquid / dispersible or rectally). NSAID benefits may outweigh risks in a dying individual; can help bone, joint, pressure sore, inflammatory pain.
- Convert any regular oral Morphine or Oxycodone to a 24 hour, SC infusion
  
  - e.g. oral Morphine 30mg = SC Morphine 15mg = SC Diamorphine 10mg
  
  - e.g. oral Oxycodone 15mg = SC Oxycodone 7-8 mg
- For opioid dose conversions, see: conversion charts and/or seek advice.
- Fentanyl patches should be continued in dying individuals. (See: Fentanyl patches)
- For individuals with stage 4-5 chronic kidney disease, see: Last days of life (renal) guideline.
- Breakthrough analgesia, should be prescribed hourly as required:
  - 1/6th of 24 hour dose of any regular opioid orally and subcutaneously.
  - If not on any regular opioid, prescribe Diamorphine SC 2.5mg-5mg 2-4hrly PRN.

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**Agitation/delirium**

<table>
<thead>
<tr>
<th>Anxiety / distress</th>
<th>Midazolam SC 2.5mg-5mg, hourly, as required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confusion / delirium</td>
<td>Haloperidol SC 2mg-5mg, once or twice daily</td>
</tr>
<tr>
<td>Established terminal delirium/ distress</td>
<td>Midazolam SC 20-30mg over 24hours in a syringe pump</td>
</tr>
<tr>
<td></td>
<td>Consider Levomepromazine SC 25-50mg PRN stat dose 6-12 hourly, as required.</td>
</tr>
<tr>
<td></td>
<td>Stop Haloperidol.</td>
</tr>
</tbody>
</table>
**Respiratory tract secretions**

- Avoid fluid overload; assess fluid balance, stop IV/SC fluids and tube feeding.
- Changing the individual’s position may help.
- Intermittent SC injections often work well or medication can be given as a SC infusion.

<table>
<thead>
<tr>
<th>Hyoscine Hydrobromide SC 400micrograms, 4-6 hourly PRN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternatively</td>
</tr>
<tr>
<td>Glycopyrronium Bromide SC 200micrograms, 6-8 hourly PRN</td>
</tr>
</tbody>
</table>

*See Care of the Dying – Medication Guidance*

**Nausea/vomiting**

- If already controlled with an oral anti-emetic, use the same drug as a SC infusion.
- Treat new nausea/vomiting with a long acting anti-emetic given by SC injection or give a suitable antiemetic as a SC infusion in a syringe pump.
  - long acting anti-emetics: Haloperidol SC 1.5mg 12 hourly.
  - Levomepromazine SC 6.25mg-12.5mg PRN 6hrly.
- Doses of antiemetics for use in a SC infusion - See: chart.
- Persistent vomiting: an NG tube, if tolerated, may be better than medication.
**Breathlessness**

**In the last days of life**

- Plan management of breathlessness in the last days of life with the individual and family.
  - Discuss the option of sedation in the event of increasing distress.
  - Prescribe anticipatory medication, as required, for symptom control.
- If the individual is unable to take oral medication, convert to the subcutaneous route.
- Oxygen is only useful if hypoxic; nasal prongs may be better tolerated; a fan or changing the individual's position can help.
- Avoid fluid overload, consider stopping any clinically assisted (artificial) hydration or nutrition.
- Suction can be distressing and may not improve respiratory secretions. Consider a nicotine replacement patch for heavy smokers.

**Intermittent breathlessness / distress**

Midazolam SC 2.5mg-5mg hourly, as required and/or Lorazepam sublingual 0.5mg-1mg, 4-6 hourly, PRN.

Opioid (2 hourly as required; titrate dose)
  - on a regular opioid → 25% of the 4 hourly, breakthrough analgesic dose.
  - not on an opioid → Diamorphine SC 2.5mg.

**Persistent breathlessness / distress**

Midazolam SC 5-20mg via syringe driver over 24 hours
+ Diamorphine SC 5-10mg (if no previous opioid use)
  or
Convert from current oral opioid dose (see: conversion charts) in a syringe pump over 24 hours. Start with low doses and titrate.

**Respiratory tract secretions**

1st line: Hyoscine Hydrobromide SC 400micrograms or Glycopyrronium Bromide SC 200micrograms, 4-6hrly hourly as required.

**Non-drug management**

- Holistic assessment and a multi-professional approach are essential.
- Enhance coping and functional ability using controlled breathing and anxiety management techniques, and by planning and pacing activities.
- Consider need for equipment/aids and a package of care.
- If prognosis is longer, a breathlessness support service, if available may help.

**Practice points**

- Starting opioids at a low dose and titrating carefully is safe and does not cause respiratory depression in individuals with cancer, airways obstruction or heart failure.
- Non-drug measures that maximise individual coping are essential. As the illness progresses, medication to relieve breathlessness becomes more necessary.
- Plan management of breathlessness in the last days of life with individual and family.

**Individual/ carer advice points**

- Keep the room well ventilated: open a window, use a fan, and keep face cool.
- Anxiety /panic are distressing but do not cause harm or worsen the individual’s condition.

Author: Cheryl Young, Practice Development Nurse End of Life Care
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Transdermal Fentanyl Patches

See also Pain Management (Section 2 – Resource File)

- Transdermal fentanyl is for use in individuals with stable pain. It should not be used for titration against rapidly escalating pain.
- Never use transdermal fentanyl patches in opioid naïve individuals, as this may lead to dangerous respiratory depression.
- The starting dose of transdermal fentanyl is calculated on the basis of the oral Morphine sulphate equivalent dose as listed in the conversion chart below.

<table>
<thead>
<tr>
<th>Total 24 hour oral morphine mg</th>
<th>Fentanyl patch mcg/hour</th>
</tr>
</thead>
<tbody>
<tr>
<td>60-134</td>
<td>25</td>
</tr>
<tr>
<td>135-224</td>
<td>50</td>
</tr>
<tr>
<td>225-314</td>
<td>75</td>
</tr>
<tr>
<td>315-404</td>
<td>100</td>
</tr>
</tbody>
</table>

- Continue to administer oral Morphine Sulphate for 12 hours after applying the first patch, i.e.:
  - Immediate release Morphine Sulphate 4 hourly for 12 hours, or the final dose of modified release Morphine Sulphate, taken at the same time as applying the first patch.
  - For breakthrough pain, prescribe immediate release Morphine Sulphate equivalent to the 4 hourly dose. This may be required for the first 24-48 hours of transdermal Fentanyl use.

In the terminal Phase

When considering the use of transdermal Fentanyl it may be appropriate to discuss the individual’s requirements with the Palliative Care Team.

- The Fentanyl patch should continue to be replaced every three days unless there are toxic opioid side effects. Leave the patch in situ when the individual can no longer tolerate oral medication. It should not be discontinued.
- If a new, opioid responsive pain develops, use subcutaneous Morphine as required for breakthrough pain. Use the conversion chart to calculate the dose of Morphine.
- After 24 hours, the breakthrough doses of Morphine given in that period can be totalled and this dose of Morphine administered as a SC infusion in a syringe pump over the next 24 hours.
- The diamorphine syringe pump should be used in addition to the fentanyl patch.

4 hourly dose of Diamorphine = \text{Fentanyl patch strength} \text{ (micrograms /hour)} \\
\text{Subcutaneously} \quad (mg) = \frac{5}{5}

Author: Cheryl Young, Practice Development Nurse End of Life Care
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Fentanyl is approximately 4 times more potent than oral Morphine; this table provides a guide to dose conversions, but if in doubt seek advice.

<table>
<thead>
<tr>
<th>Fentanyl patch strength (micrograms / hour)</th>
<th>4 hourly dose of Diamorphine subcutaneously (mg)</th>
<th>4 hourly dose of Morphine subcutaneously (mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>5</td>
<td>5-10</td>
</tr>
<tr>
<td>50</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>75</td>
<td>15</td>
<td>25</td>
</tr>
<tr>
<td>100</td>
<td>20</td>
<td>30</td>
</tr>
<tr>
<td>150</td>
<td>30</td>
<td>45</td>
</tr>
<tr>
<td>200</td>
<td>40</td>
<td>60</td>
</tr>
</tbody>
</table>

**Discontinuation of transdermal Fentanyl**
- Discontinuation of transdermal Fentanyl is not straightforward, primarily because of the intradermal reservoir of drug which remains following removal of the patch.
- Caution must be exercised, since the addition of alternative opioids may result in significant respiratory depression.
- For advice on discontinuing fentanyl and using another opioid, **always** contact the Palliative Care Team, or hospice out-of-hours.

**For advice on concomitant syringe pump and transdermal Fentanyl medication at the end-of-life, always contact the Palliative Care Team or hospice.**

**Palliative Care CNS Team - Tel No. 647475 (Mon-Fri 9-5pm)**
**Hospice IPU – Tel No. 647400**
Syringe Pump

The McKinley T34 syringe pump is the only 24 hour pump to be used for symptom management of Palliative Care Individuals.

All staff who use the McKinley T34 syringe pump must have undertaken training before they use the pump as part of their care.

- Drugs should be mixed with water for injection unless contraindicated. Octreotide, Ketorolac, Ketamine should be mixed with normal saline. Please check the BNF for drug compatibilities.
- Please use conversation charts and flow diagrams for guidance when prescribing medication for a syringe pump.

Drug compatibility

It is common to see two drugs in a syringe driver, but if more drugs than this are required for symptom management it is advisable to contact the Palliative Specialist team for advice, as not all drugs are compatible or stable. Some drugs may be physically or chemically incompatible.

Factors which may affect stability/compatibility are:

- drug concentration
- brand/formulation
- diluents
- time interval
- temperature of surroundings
- exposure to light
- order of mixing
- delivery system material.

Common combinations

Strong opioid + Anti-emetic
Strong opioid + Anti-emetic + Anti-cholinergic
Strong opioid + Anti-emetic + Anxiolytic
Strong opioid + Anti-emetic + Anti-cholinergic + Anxiolytic

The most commonly used syringes are a 20ml luer lock syringes. A larger dilution will reduce both the risks of adverse site reactions and incompatibility and it also accommodates large doses of medications.

It is therefore recommended that 20ml should be used and that it MUST have a luer lock facility in order to avoid leakage or accidental disconnection. Occasionally a 30ml luer lock syringe may be required.

- Use a 20ml luer lock syringe and draw up the prescribed medication and diluents to 17mls.
- If a 30ml luer lock syringe is recommended, draw up the medication and diluents to 23.5ml.

Please refer to 'McKinley T34 Syringe Pump Guidelines in Resource File

Author : Cheryl Young, Practice Development Nurse End of Life Care
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Date of review 12/05/15
Syringe driver drug compatibility & stability charts

Table 1. Subcutaneous Diamorphine infusion in a Syringe Driver

**Diluent: Water for injections**

*These are not clinical doses to prescribe. Most patients do not need such high doses. Read the relevant guidelines.*

- Use this table to check for concentrations that are stable.
- Refer to the relevant guideline to obtain the usual dose range for each of the medications. Use
- the minimum effective dose and titrate according to response.

<table>
<thead>
<tr>
<th>Drug Combination</th>
<th>Concentrations of <strong>TWO</strong> drug combinations that are physically stable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>20ml syringe (17ml)</strong></td>
</tr>
<tr>
<td>Diamorphine</td>
<td>280mg</td>
</tr>
<tr>
<td>Cyclizine</td>
<td>150mg</td>
</tr>
<tr>
<td>Diamorphine</td>
<td>350mg 1000 micrograms</td>
</tr>
<tr>
<td>Glycopyrronium</td>
<td></td>
</tr>
<tr>
<td>Bromide</td>
<td></td>
</tr>
<tr>
<td>Diamorphine</td>
<td>600mg 10mg</td>
</tr>
<tr>
<td>Haloperidol</td>
<td></td>
</tr>
<tr>
<td>Diamorphine</td>
<td>1200mg 120mg</td>
</tr>
<tr>
<td>Hyoscine Butylbromide</td>
<td></td>
</tr>
<tr>
<td>Diamorphine</td>
<td>1200mg 1200 micrograms</td>
</tr>
<tr>
<td>Hyoscine Hydrobromide</td>
<td></td>
</tr>
<tr>
<td>Diamorphine</td>
<td>80mg 30mg</td>
</tr>
<tr>
<td>Ketorolac</td>
<td></td>
</tr>
<tr>
<td>Diamorphine</td>
<td>700mg 100mg</td>
</tr>
<tr>
<td>Levomepromazine</td>
<td></td>
</tr>
<tr>
<td>Diamorphine</td>
<td>2100mg 70mg</td>
</tr>
<tr>
<td>Metoclopramide</td>
<td></td>
</tr>
<tr>
<td>Diamorphine</td>
<td>450mg 70mg</td>
</tr>
<tr>
<td>Midazolam</td>
<td></td>
</tr>
<tr>
<td>Diamorphine</td>
<td>350mg 900 micrograms</td>
</tr>
<tr>
<td>Octreotide</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drug Combination</th>
<th>Concentrations of <strong>THREE</strong> drug combinations that are physically stable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>20ml syringe (17ml)</strong></td>
</tr>
<tr>
<td>Diamorphine</td>
<td>280mg</td>
</tr>
<tr>
<td>Cyclizine</td>
<td>150mg</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>10mg</td>
</tr>
<tr>
<td>Diamorphine</td>
<td>600mg 5mg</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>5mg</td>
</tr>
<tr>
<td>Midazolam</td>
<td>55mg</td>
</tr>
<tr>
<td>Diamorphine</td>
<td>95mg 60mg 15mg</td>
</tr>
<tr>
<td>Hyoscine Butylbromide</td>
<td></td>
</tr>
<tr>
<td>Midazolam</td>
<td></td>
</tr>
<tr>
<td>Diamorphine</td>
<td>700mg 100mg 40mg</td>
</tr>
<tr>
<td>Levomepromazine</td>
<td></td>
</tr>
<tr>
<td>Metoclopramide</td>
<td></td>
</tr>
<tr>
<td>Diamorphine</td>
<td>700mg 40mg 20mg</td>
</tr>
<tr>
<td>Levomepromazine</td>
<td></td>
</tr>
<tr>
<td>Midazolam</td>
<td></td>
</tr>
</tbody>
</table>
Table 2: Subcutaneous Oxycodone infusion in a Syringe Driver

Diluent: Water for injections
These are not clinical doses to prescribe.
Most patients do not need such high doses. Read the relevant guidelines.

- Use this table to check for concentrations that are stable.
- Refer to the relevant guideline to obtain the usual dose range for each of the medications. Use the minimum effective dose and titrate according to response.
- The concentration of Oxycodone injection is 10mg/ml. If the 24hour dose of Oxycodone exceeds 60mg, an alternative opioid may be needed for breakthrough pain.

<table>
<thead>
<tr>
<th>Drug Combination</th>
<th>Concentrations of TWO drug combinations that are physically stable</th>
<th>20ml syringe (17ml)</th>
<th>30ml syringe (23.5ml)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxycodone</td>
<td>Do not mix - Incompatible</td>
<td>120mg 7.5mg</td>
<td>140mg 10mg</td>
</tr>
<tr>
<td>Cyclizine</td>
<td></td>
<td>120mg 30mg</td>
<td>140mg 40mg</td>
</tr>
<tr>
<td>Oxycodone</td>
<td></td>
<td>100mg 120mcg</td>
<td>130mg 1200mcg</td>
</tr>
<tr>
<td>Haloperidol</td>
<td></td>
<td>70mg 30mg</td>
<td>85mg 30mg</td>
</tr>
<tr>
<td>Oxycodone</td>
<td></td>
<td>100mg 100mg</td>
<td>120mg 100mg</td>
</tr>
<tr>
<td>Hyoscine Butylbromide</td>
<td></td>
<td>70mg 35mg</td>
<td>80mg 40mg</td>
</tr>
<tr>
<td>Oxycodone</td>
<td></td>
<td>70mg 35mg</td>
<td>80mg 40mg</td>
</tr>
<tr>
<td>Hyoscine Hydrobromide</td>
<td></td>
<td>70mg 30mcg</td>
<td>80mg 400mcg</td>
</tr>
<tr>
<td>Oxycodone</td>
<td></td>
<td>70mg 2.5mg</td>
<td>80mg 2.5mg</td>
</tr>
<tr>
<td>Ketorolac</td>
<td></td>
<td>70mg 2.5mg</td>
<td>80mg 2.5mg</td>
</tr>
<tr>
<td>Oxycodone</td>
<td></td>
<td>70mg 2.5mg</td>
<td>80mg 2.5m</td>
</tr>
<tr>
<td>Levomepromazine</td>
<td></td>
<td>70mg 2.5mg</td>
<td>80mg 2.5m</td>
</tr>
<tr>
<td>Oxycodone</td>
<td></td>
<td>70mg 2.5mg</td>
<td>80mg 2.5m</td>
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Key references

Author :Cheryl Young, Practice Development Nurse End of Life Care
Date of issue: 12/05/2014
Date of review 12/05/15
**Breakthrough Pain**

‘Breakthrough’ is a term that is used to indicate that a symptom has re-occurred even with the use of regular medications to control that symptom. This medication should be given at the first sign of an unwanted symptom, before it has a chance to build up, remembering that medications can take up to 20 minutes to take effect.

**Analgesic Route**

- The oral route is the preferred route of analgesic administration when an individual is physically able to take oral medication.
- Transdermal Fentanyl is appropriate in the setting of severe continuous pain in individuals who cannot use the oral route; **however, this product is not suitable for unstable pain management.**
- The intramuscular route should be avoided as it is generally more painful, and has variable absorption, compared to other routes. The subcutaneous route is preferred when a parenteral route is needed.
  - If the syringe pump is being used to administer opiate analgesia such as **Diamorphine**, then extra breakthrough analgesia must be prescribed and administered as a subcutaneous injection.
  - Dosage will be calculated as a **sixth** of the **total 24 hour infusion**.
  - Separate subcutaneous injections should be prescribed as required.

**The commonly used drugs listed below must NOT be given by the SC route as they may cause tissue necrosis:**

- Antibiotics
- Diazepam
- Chlorpromazine
- Prochlorperazine (stemetil®)
Points to consider

1. Opioid analgesics should not be used to sedate dying individuals.

2. Sudden increase in pain or agitation; exclude urinary retention, constipation; other reversible causes.

3. Subcutaneous infusions provide maintenance treatment only.

4. Additional doses of medication by SC injection will be needed if the patient’s symptoms are not controlled.

5. Midazolam is titrated in 5-10 mg steps. Up to 5mg can be given in a single SC injection (1ml). Useful as an anticonvulsant.

6. Single SC doses can last 2-4 hours.

7. Rectal Diazepam solution; longer acting alternative to Midazolam given PR or via a stoma.

8. Terminal secretions can be controlled in about 60% of cases; fluid overload, aspiration and respiratory infection increase incidence.

9. Consider a nicotine replacement patch for heavy smokers.
# Opioid Equianalgesic Table

This chart should be only used as a guide. The titration to optimum pain control should always be individualised.

(Initial dose conversions should be conservative; it is preferable to under-dose the individual and use rescue medication for any shortfalls).

<table>
<thead>
<tr>
<th>Oral Morphine</th>
<th>MST or Zomorph</th>
<th>MXL Oxynorm (Oxycodone IR) 4hrly</th>
<th>Oral Oxycontin (Oxycodone MR) 12hrly</th>
<th>Transtec Patch (Buprenorphine patch) 72hrly</th>
<th>Durogesic and Durogesic D-trans (Fentanyl Patch) 72hrly</th>
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<td>35mcg/hr</td>
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</tbody>
</table>

These tables have been generated using values that may differ from manufacturers’ recommendations, but are based on expert opinion.

* Taken from Merseyside and Cheshire Palliative Care Guidelines 2010

Author : Cheryl Young, Practice Development Nurse End of Life Care
Date of issue: 12/05/2014
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Opioid Equianalgesic Table

This chart should be only used as a guide. The titration to optimum pain control should always be individualised.

(Initial dose conversions should be conservative; it is preferable to under-dose the individual and use rescue medication for any shortfalls).

For further guidance especially with renal failure – refer to Palliative Care Resource File

<table>
<thead>
<tr>
<th>MST or Zomorph</th>
<th>MXL daily</th>
<th>Durogesic and Durogesic D- trans (Fentanyl Patch) 72hrly</th>
<th>Transtec Patch (Buprenorphine patch) 72hrly</th>
<th>DiaMorphine s/c PRN 2hrly PRN</th>
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Taken from Merseyside and Cheshire Palliative Care Guidelines 2010

Author: Cheryl Young, Practice Development Nurse End of Life Care
Date of issue: 12/05/2014
Date of review 12/05/15
Care of the Dying Individual – Medication Guidance

Pain

1. Prescribe DIAMORPHINE 2.5mg-5mg s/c prn
2. If patient is already taking oral opioids(s) – convert from oral to s/c syringe pump.

To convert from oral MORPHINE to 24hr sc infusion of DIAMORPHINE
Divide the total daily dose of MORPHINE by 3

To convert from oral ORAMORPH to 24hr sc infusion of OXycodone
Divide the total daily dose of OXycodone by 2

To convert from oral OXycodone to 24hr sc infusion of DIAMORPHINE
Multiply the total daily dose of OXycodone by 2 and then divide by 3 (2/3)

Breakthrough dose should be 1/6 of the total daily dose of strong opioids.

Patient is in pain

1. Administer DIAMORPHINE s/c prn.
2. Liaise with Palliative Care Team.
3. Continue to give prn dosage accordingly.
4. Review this every 24hrs.

If 3 or more prn doses required in 24hrs set up syringe pump if not already commenced.

or

Increase dose already in syringe pump.

Doses via syringe pump should be titrated according to total 24hr PRN doses

Patient has no pain

Review this every 24hrs

- Anticipatory prescribing will ensure that in the last hours / days of life there is no delay responding to a symptom if it occurs.

Author: Cheryl Young, Practice Development Nurse End of Life Care
Date of issue: 12/05/2014
Date of review 12/05/15
Terminal restlessness and agitation

1. Prescribe MIDAZOLAM 2.5 - 5mg s/c prn

Present

1. Administer MIDAZOLAM s/c prn.
2. Liaise with Palliative Care Team.
3. Continue to give prn dosage accordingly.
4. Review this every 24hrs.
If 3 or more prn doses required in 24hrs, consider syringe pump if not already commenced.
   or
Increase dose already in syringe pump.
Doses via syringe pump should be titrated according to total 24hr PRN doses

Absent

Review this every 24hrs

- If the person is still agitated – consider LEVOMEPROMAZINE s/c 25-50mg prn.
  LEVOMEPROMAZINE 50-200mg via McKinley syringe pump s/c over 24hrs
  (please note smaller doses are used for nausea and vomiting)

- Anticipatory prescribing will ensure that in the last hours / days of life there is no delay responding to a symptom if it occurs.
Care of the Dying Individual – Medication Guidance

**Respiratory tract secretions**

Prescribe HYOSCINE HYDROBROMIDE 0.4mg s/c prn

1. Present
   - Administer HYOSCINE HYDROBROMIDE 0.4mg s/c injection.
   - Prescribe and set up syringe pump with HYOSCINE HYDROBROMIDE 1.2mg over 24hrs s/c.
   - Continue to give prn dosage accordingly.
   - Review this every 24hrs.

2. Absent
   - Review this every 24hrs.

   If 2 or more prn doses required in 24hrs increase total 24hr dose via syringe pump to 2.4mg after 24hrs if symptoms persist.

- GLYCOPHRONIUM 0.2mg s/c injection may be used as an alternative.
- Anticipatory prescribing in this manner will ensure that in the last hours/days of life there is no delay responding to a symptom if it occurs.
Nausea and vomiting

Prescribe CYCLIZINE 50mg s/c 8hrly prn

Present

1. Administer CYCLIZINE 50mg s/c injection.

2. Liaise with Palliative Care Team.

3. Continue to give prn dosage accordingly.

4. Review this every 24hrs.

If 3 doses required in 24hrs, set up syringe pump with CYCLIZINE 150mg s/c over 24hrs

Absent

Review this every 24hours

Consider an alternative antiemetic if previous one is not effective.

- CYCLIZINE is **not** recommended in people with heart failure.

- Alternative antiemetics may be prescribed e.g.
  - HALOPERIDOL s/c 2.5mg – 5mg prn
    (5mg – 10mg via McKinley syringe pump s/c over 24 hrs)
  - LEVOMEPEMAZINE s/c 6.25mg prn
    (12.5mg – 25mg via McKinley syringe pump s/c over 24hrs.)

- Anticipatory prescribing in this manner will ensure that in the last hours/days of life there is no delay responding to a symptom if it occurs.

Author: Cheryl Young, Practice Development Nurse End of Life Care
Date of issue: 12/05/2014
Date of review 12/05/15
Dyspnoea

1. Prescribe DIAMORPHINE 2.5mg – 5mg s/c prn

---

Present

Are they already taking oral morphine for breathlessness?

Yes

1. Administer DIAMORPHINE s/c prn.
2. Liaise Palliative Care Team.
3. Convert from oral opioids to a syringe pump.
   (See guidance)
4. Review this every 24hrs.
Doses via syringe pump should be titrated according to total 24hr PRN doses

No

1. Administer DIAMORPHINE s/c prn
2. Set up syringe pump with DIAMORPHINE 10mg s/c over 24hrs.
3. Review this every 24hrs.

---

Absent

Review this every 24hrs

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- If the person is breathless and anxious - consider MIDAZOLAM stat 2.5mg s/c prn.
- Anticipatory prescribing in this manner will ensure that in the last hours/days of life there is no delay responding to a symptom if it occurs.
Nursing Home Individuals
Communication between the Home and the General Practitioner

Key points for effective communication between the Nursing Home and General Practitioner

- Preparation – know the key facts.
- Be clear about what you want and why you want it.
- Be clear regarding the agreed plan of management.
- Record details of the conversation in the person’s notes.

Three triggers that suggest that patients are nearing the end of life are:

1. The Surprise Question: ‘Would you be surprised if this patient were to die in the next few months, weeks, days’?
2. General indicators of decline - deterioration, increasing need or choice for no further active care.
3. Specific clinical indicators related to certain conditions.

Are there general indicators of decline and increasing needs?
- Decreasing activity – functional performance status declining (e.g. Barthel score limited self-care, in bed or chair 50% of day) and increasing dependence in most activities of daily living
- Co-morbidity is regarded as the biggest predictive indicator of mortality and morbidity
- General physical decline and increasing need for support
- Advanced disease - unstable, deteriorating complex symptom burden
- Decreasing response to treatments, decreasing reversibility
- Choice of no further active treatment
- Progressive weight loss (>10%) in past six months
- Repeated unplanned/crisis admissions
- Sentinel Event e.g. serious fall, bereavement, transfer to nursing home
- Serum albumen <25g/l
- Considered eligible for DS1500 payment (see benefits)

Further information and other prognostic guidance is available from www.goldstandardsframework.nhs.uk

Author: Cheryl Young, Practice Development Nurse End of Life Care
Date of issue: 12/05/2014
Date of review 12/05/15
## ISLE OF MAN END OF LIFE CARE MODEL

### Advancing Disease
- **Months (<1 year)**
  - **Diagnosis more than a year**
    - Holistic patient assessment (including physical, spiritual social, psychological domains)
    - Carer needs assessment
    - Consider Advance Care Planning discussion, consider using document
    - Inclusion on Supportive & Palliative Care Register, Gold Standard Framework (GSF)
    - Refer to community services District Nurse / Social Worker
    - Check Benefits (Disability Living Allowance / Attendance Allowance DS1500)
    - Consider Manx Emergency Doctors Service Form (MEDS)
  - **Stable disease**
    - Optimise medications
    - Rationalise medications
    - Check benefits (Disability Living Allowance / Attendance Allowance)
    - Consider DNACPR
    - Update MEDS Form; Advance Care Plan/ DNACPR
  - **Increasing decline (<6 months)**
    - Review care plan (including social care needs)
    - Initiate Advance Care Planning discussion, consider using document
    - Consider other health funding
    - Consider DNACPR, (if not already completed)
    - Update MEDS Form; Advance Care Plan; Special Patient Alert Form DNACPR
  - **Last days of life (last weeks of life)**
    - Review care plan (including Advance Care Plan and Preferred Place of Care)
    - If in hospital: Consider Rapid Discharge to Preferred Place of Care
    - If in hospital: Consider 4 Hour Discharge to Preferred Place of Death
    - Discuss, prescribe and supply ‘Just in Case Box and medication
    - Discuss, prescribe and supply ‘Just in Case 4 Core Drugs’, (if not already in situ)
    - Arrange equipment for end of life care at home, including, bed, other equipment, etc
    - Discuss support for end of life care at home
    - Identify ‘at risk’ bereavement
  - **After Care Bereavement**
    - Verification of death
    - Certification of death
    - Bereavement information booklet given to relatives
    - Bereavement support; Counselling support; Psychological support
    - Discuss After Death Significant Event Analysis where appropriate

### Consider referral to:
Palliative Care Clinical Nurse Specialist Team; District Nurse; Social Worker; Chaplaincy; Voluntary Service.

### Consider training in:
End of Life Care; Communication Skills; Carer support; Psychological support; Spiritual assessment.

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Author: Cheryl Young, Practice Development Nurse End of Life Care
Date of issue: 12/05/2014
Date of review 12/05/15

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Nursing Home Guidance

Is the resident on your end of life care register? BEFORE YOU CALL 999...

HAS! – the individual got DNA-CPR (do not attempt cardiopulmonary resuscitation) or an Advanced Directive to Refuse Treatment (ADRT)?

OPTIONS! – are the symptoms acute or longstanding? What medication / treatments have been trialled? Might symptoms be better managed with a different route of administration?

SYMPTOMS! – can any of the symptoms be reversed by any treatment that you can give? Have you liaised with the G.P./Palliative Care Team for advice?

PPC! Does the individual have an advance care plan e.g. Preferred Priorities for Care (PPC)? Consider, does the individual wish to be transferred to hospital or to be managed within the care home?

IS! the individual entering the dying phase of their life? Consider if the person is well enough to be moved.

TEAM! Has the multidisciplinary team (MDT) identified this individual as coming to the end of their life? If so, have the MDT been involved in the decision to transfer the individual to hospital.

AMBULANCE SERVICE! If the individual has a PPC, ADRT and/or DNA-CPR in place and needs to be transferred by ambulance to hospital, you need to inform the service and have copies of these documents available with the transfer form.

LISTEN TO THE INDIVIDUAL & FAMILY! Have you discussed with the individual/family their possible admission to hospital? Have you discussed with the individual/family that PPC may not be achieved if they are admitted to hospital.

N.B If the individual is not in the dying phase of life and symptoms are acute and potentially reversible then admission would be appropriate with a view to rapid discharge back home.

Author: Cheryl Young, Practice Development Nurse End of Life Care
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Remember
Recognise deterioration in an individual.

Could this be a sign that they are dying?

1. Contact their G.P. / Consultant / Hospice Physician
   Do they really need admission to Hospital? (community)
2. Keep the individual / family informed of any changes in care.
3. Contact other members of the MDT to inform them of individual’s present condition and needs.
4. Consider Advance Wishes / Advance Care Plan.
5. Has a Do Not Resuscitation Order been done? If not, Review Do Not Attempt Cardiopulmonary Resuscitation Order. Documentation (according to local policy and procedure) completed. Explanation given to patient if appropriate, and relatives or carers.
6. Has a Special Alert form been completed and faxed to Manx Emergency Doctors Service (MEDS) (community only).
7. Assess and monitor symptoms as they occur.
8. Prescribe anticipatory medication – convert oral to s/c
9. Control symptoms with prescribed medication.
10. Consider a syringe pump - discuss as far as possible the reasoning with the patient, their relatives or carers.
11. Support the patient to take food and fluids by mouth for as long as tolerated. Communicate to them if appropriate, and their relatives or carers the reduced need for food and fluids (part of the dying process).
12. If the patient has an Implantable Cardioverter Defibrillator (ICD), contact the patient’s cardiologist. Refer to ECG technician and to local guidelines re deactivating it.
13. Anticipate and be prepared for any specific religious, spiritual or cultural needs a patient might have.
14. If the patient is an Insulin Dependent Diabetic, contact Diabetes CNS for further guidance.
15. On rare occasions a patient’s condition may improve. Seek a second opinion or specialist palliative care support as needed.

For further advice or referral please do not hesitate to contact the Palliative Care Clinical Nurse Specialists, Hospice Isle of Man.
Tel No. 647475 or Fax 647460

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