# Health Services Directorate

# STANDARD OPERATING PROCEDURE (SOP)
# For the management of patients at the end of life

## Introduction

The purpose of this SOP is to provide further operational guidance to staff working within Department of Health and Hospice in relation to the caring for dying, deceased patients, and their relatives.

The guidance contained within this document has been compiled to assist staff in understanding the issues around death and dying, and to provide them with advice on how to maintain patients' privacy, dignity and respect. Staff are expected to maintain a caring and sensitive attitude to relatives of the dying and deceased patient. It is vital that a culture of compassion, sympathy and dignity are preserved at all times when caring for a dying patient and relatives.

We also need to recognise that we, as care givers and our colleagues, who are involved in the care process, may also be affected at this emotional and stressful time.

**The term "relative" used throughout this policy is applicable to all family members and friends of the dying/deceased patient.**

## Scope

This SOP applies to all health care professionals directly involved in the care for the dying patient and their relatives.

This policy provides guidance for staff at this stressful time to ensure the best possible standard of care for all dying patients and their relatives before, during and after death. By building on existing services and established practices we will provide the highest quality of care to all concerned.

The standards of care are based on the End of Life Care Strategy (DH, 2008) and reflect recent National Policy guidance.

**Roles and Responsibilities**

End of life care includes 24-hour care availability to manage pain and symptoms and support to the family by providing expert management of pain and other symptoms combined with compassionate listening and counselling skills, the best quality end of life care for the patient and relatives can be provided.

- Care of the dying person requires regular assessment and involves regular reflection, in the best interest of the patient.

- A named consultant or G.P. should take overall responsibility for the care of patients who are dying in hospital, hospice or the community.

- Be aware of the processes that occur during the last days of life and be alert to the possibility that on rare occasions a patient's condition may improve. Seek a second opinion or specialist palliative care support as needed

- Changes in care should be made in the best interest of the patient and their family and needs to be reviewed regularly by the multidisciplinary team (MDT). Patient's and relative's wishes and preferences should be discussed and an agreed set of actions recorded in an individualised care plan.

- Good comprehensive clear communication is pivotal and all decisions leading to a change in care delivery should be communicated to the patient where appropriate and to the relative.

- Anticipate and be prepared for any specific religious, spiritual or cultural needs a patient might have.

- Medication is prescribed on a as required only basis for symptoms that may develop in the last hours or days of life. Just in Case Box protocol is used in the community setting. (See also End of life Flow Charts)

- Before a syringe driver is commenced, this must be discussed as far as possible with the patient, their relatives or carers, and the reasoning documented.

- The patient should be supported to take food and fluids by mouth for as long as tolerated. A reduced need for food and fluids as part of the dying process and this should be communicated to the patient if appropriate and their relative or carer. Don't artificially hydrate the dying patient, in most cases.

- A Do Not Attempt Cardiopulmonary Resuscitation Order is in place. Documentation (according to local policy and procedure) is completed. Explanation is also given to patients and relatives as appropriate. (Awaiting community policy)

- If the patient has an Implantable Cardioverter Defibrilator (ICD), contact the patient's cardiologist. Refer to ECG technician and to local guidelines re deactivating it.

- Should the patient be an Insulin Dependent Diabetic, contact Diabetes Nurse Specialist for further guidance and End of Life Flow Charts.

- Measurement of end-of-life care through audit andresearch, which should look into the structure, process and outcome of end of life care.

**Documentation**

The senior clinician should write in the patient's notes a record of the face to face conversation in which the end of life plan of care was first discussed with the patient and their relative. The record of that conversation must include the following:

- That the clinician explained that the patient is now dying and when and how death might be expected to occur.
- If the relatives do not accept that the patient is dying, the clinician has explained the basis for that judgement.
- That the relatives or carers had the opportunity to ask questions.

**Ongoing assessment should be recorded by the multi disciplinary team after each significant event; conversations; medical review; visit by other specialist teams and if a second opinion is sought.**

**Care after Death**

- When the patient dies, verification of death should be recorded according to local guidelines. Death certified and appropriate documentation completed.

- Last offices are undertaken according to policy and procedure.

- Information is given to families on what they need to do following the death of their loved one. Ensure relevant written information is given.

- Ensure the appropriate services across the health organisation are informed. e.g. palliative care team, social worker, OT, Physiotherapist, DN etc.

- Bereavement care leaflet/pack is offered to the relatives and referral to bereavement team if wanted and/or necessary.

**Audit**

- As part of the National Care of the Dying Audit in Hospitals. (NCDAH Round 4)

**Useful Resources**

End of Life Care Strategy (DH, 2008)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136431/End_of_life_strategy.pdf.

Independent review of the Liverpool Care Pathway: More Care Less Pathway
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212450/Liverpool_Care_Pathway.pdf.

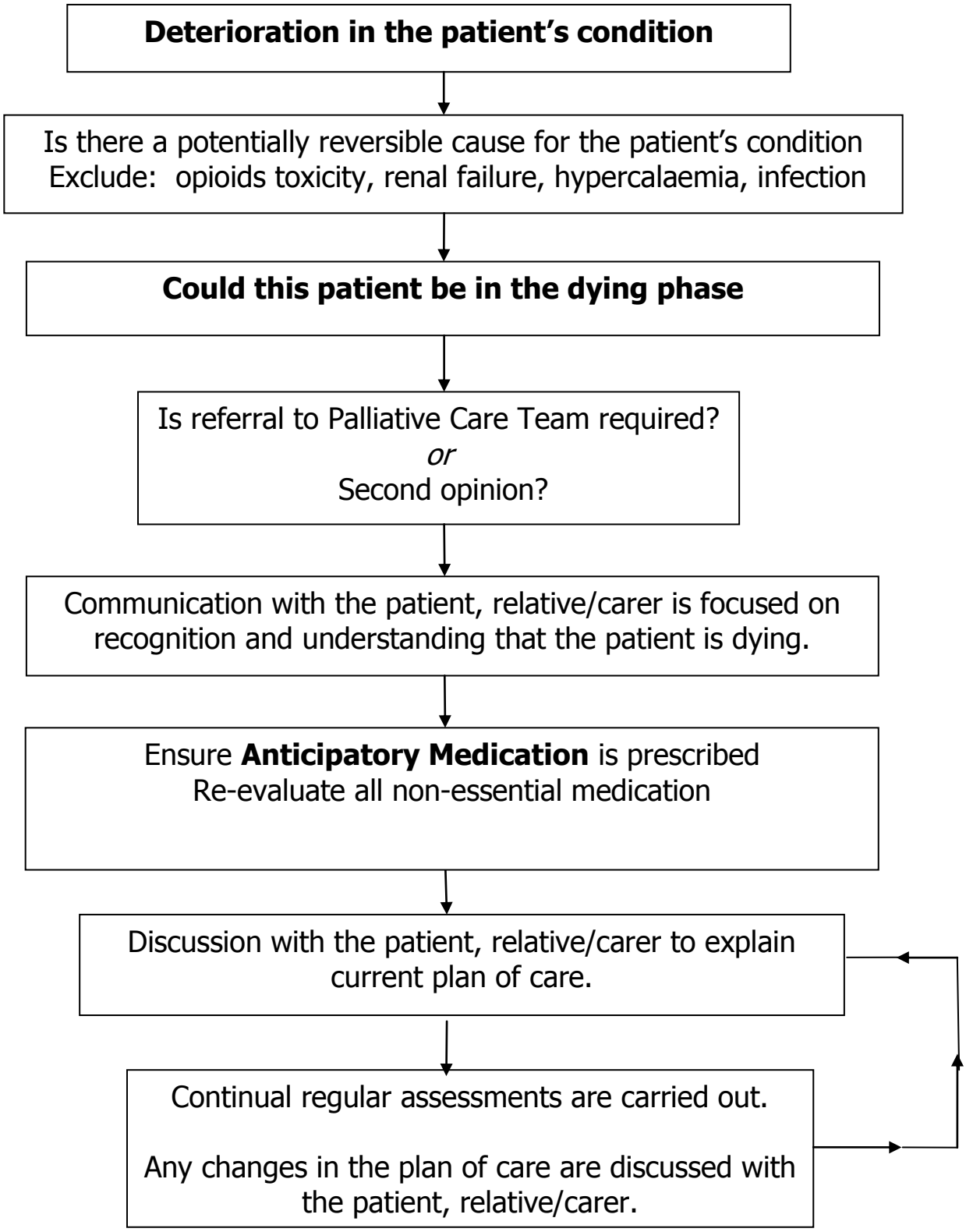
National End of Life Care Programme Website:
https://www.endoflifecareforadults.nhs.uk/education-and-training/communication-skills.

Sigurdardottir, K.R., Haugen, D.F., Bausewein, C., Higginson, I.J., Harding, R., Rosland J.H., Kaasa, S. (2012) 'A pan-European survey of research in end-of-life cancer care', *Support Care Cancer*, vol.20, pp.39–48.

Steinhauser, K.E., Christakis, N.A., Clipp, E.C., McNeilly, M., McIntyre, L., Tulsky, J.A. (2000) 'Factors Considered Important at the End of Life by Patients, Family, Physicians, and Other Care Provider', *JAMA, vol.*284, no.19, pp.2476-2482.

Watts, T. (2012) 'End-of-life care pathways as tools to promote and support a good death: a critical commentary', *European Journal of Cancer Care*, vol.21, no.1, pp.20-30.

# Supporting Care for the Dying Patient and their Family




**Please refer to Palliative Care Resource File for further guidance.**

# Anticipatory Prescribing for the Dying Patient.

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

If the patient 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**.

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

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

*Antiemetic:*
**Cyclizine** injection (50mg/ml ampoules)
Dose: 50mg SC, 8 hourly as needed for **nausea**.
*or*
**Levomepromazin**e injection 25mg/ml
Dose: 6.25mg SC, 6 hourly as needed for **nausea**.

*Dilution*
**Water** for injection 10mls

# Syringe Pump

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

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

1. 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.

2. Please use conversation charts and flow diagrams for guidance when prescribing medication for a syringe pump.

# Breakthrough Pain

1. 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.

2. Dosage will be calculated as a ***sixth*** of the **total 24 hour infusion**.

3. Separate subcutaneous injections should be prescribed as required.

# Transdermal Patches

**See also Pain Management (Section 2 – Resource File)**

1. Leave the patch *in situ* when the patient can no longer tolerate oral medication.

2. Use subcutaneous injections to deliver breakthrough medication and a syringe pump to deliver the increasing analgesia requirements.

# 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 patient and use rescue medication for any shortfalls).

| **Oral Morphine**<br>**4 hrly** | **MST or Zomorph**<br>**12hrly** | **MXL**<br>**daily** | **Oral Oxynorm**<br>*(Oxycodone IR)*<br>**4hrly** | **Oxycontin**<br>*(Oxcodone MR)*<br>**12hrly** | **Transtec Patch**<br>(*Buprenorphine patch)*<br>**72hrly** | **Durogesic and Durogesic D-trans**<br>*(Fentanyl Patch)*<br>**72hrly** |
|---|---|---|---|---|---|---|
| 2.5mg | 10mg | | 1.5mg | 5-10mg | 35mcg/hr | |
| 5mg | 15mg | 30mg | 2.5mg | 10mg | 35mcg/hr | |
| 10mg | 30mg | 60mg | 5mg | 20mg | 52.5mcg/hr | 25mcg/hr |
| 20mg | 60mg | 120mg | 15mg | 40mg | 70mcg/hr | 25-50mcg/hr |
| 30mg | 90mg | 180mg | 20mg | 60mg | 105mcg/hr | 50mcg/hr |
| 40mg | 120mg | 240mg | 25mg | 80mg | 140mcg/hr | 50-75mcg/hr |
| 50mg | 150mg | 300mg | 30mg | 100mg | | 75-100mcg/hr |
| 60mg | 180mg | 360mg | 40mg | 120mg | | 100mcg/hr |
| 70mg | 210mg | 420mg | 45mg | 140mg | | 125mcg/hr |
| 80mg | 240mg | 480mg | 55mg | 160mg | | 125-150mcg/hr |
| 90mg | 260mg | 540mg | 60mg | 180mg | | 150mcg/hr |
| 100mg | 300mg | 600mg | 65mg | 200mg | | 150-175mcg/hr |
| 110mg | 330mg | 660mg | 75mg | 220mg | | 175mcg/hr |
| 120mg | 360mg | 720mg | 80mg | 240mg | | 200mcg/hr |
| 140mg | 420mg | 840mg | 95mg | 280mg | | 225-250mcg/hr |
| 160mg | 480mg | 960mg | 105mg | 320mg | | 250-275mcg/hr |
| 180mg | 540mg | 1080mg | 120mg | 360mg | | 300mcg/hr |

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

# 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 patient and use rescue medication for any shortfalls).

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

| **MST or Zomorph**<br><br>12hrly | **MXL**<br><br>daily | **Durogesic and Durogesic D-trans**<br>*(Fentanyl Patch)*<br><br>72hrly | **Transtec Patch**<br>(*Buprenorphine patch)*<br><br>72hrly | **Diamorphine s/c**<br>*PRN*<br><br>2hrly PRN | **Diamorphine s/c**<br>*Syringe Pump*<br><br>Over 24hrs | **Morphine s/c**<br>*PRN*<br><br>2hrly PRN | **Morphine s/c**<br>*Syringe Pump*<br><br>Over 24hrs |
|---|---|---|---|---|---|---|---|
| 10mg | | | 35mcg/hr | 2.5mg | 5-10mg | 5mg | 10-15mg |
| 15mg | 30mg | | 35mcg/hr | 2.5mg | 10mg | 5mg | 15mg |
| 30mg | 60mg | 25mcg/hr | 52.5mcg/hr | 5mg | 20mg | 7.5mg | 30ng |
| 60mg | 120mg | 25-50mcg/hr | 70mcg/hr | 5-10mg | 40mg | 10-15mg | 60mg |
| 90mg | 180mg | 50mcg/hr | 105mcg/hr | 10mg | 60mg | 15mg | 90mg |
| 120mg | 240mg | 50-75mcg/hr | 140mcg/hr | 15mg | 80mg | 20mg | 120mg |
| 150mg | 300mg | 75-100mcg/hr | | 15-20mg | 100mg | 20-30mg | 150mg |
| 180mg | 360mg | 100mcg/hr | | 20mg | 120mg | 30mg | 180mg |
| 210mg | 420mg | 125mcg/hr | | 20mg | 130mg | 30mg | 200mg |
| 240mg | 480mg | 125-150mcg/hr | | 20-30mg | 160mg | 30-45mg | 240mg |
| 260mg | 540mg | 150mcg/hr | | 30mg | 190mg | 45mg | 280mg |
| 300mg | 600mg | 150-175mcg/hr | | 3mg | 200mg | 45mg | 300mg |
| 330mg | 660mg | 175mcg/hr | | 30-40mg | 220mg | 45-60mg | 330mg |
| 360mg | 720mg | 200mcg/hr | | 40mg | 240mg | 60mg | 360mg |
| 420mg | 840mg | 225-250mcg/hr | | 40-50mg | 290mg | 60-75mg | 430mg |
| 480mg | 960mg | 250-275mcg/hr | | 50-60mg | 330mg | 75-90mg | 490mg |
| 540mg | 1080mg | 300mcg/hr | | 60mg | 360mg | 90mg | 540mg |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Oxycontin** 12hrly | 5mg | 10mg | 20mg | 40mg | 60mg | 80mg | 100mg | 120mg | 130mg | 160mg | 170mg | 200mg | 220mg |
| **Oxynorm** Syringe pump 24hrs | 5-10mg | 15mg | 25-30mg | 50-55mg | 80mg | 110mg | 135mg | 160mg | 175mg | 215mg | 230mg | 270mg | 300mg |

*Taken from Merseyside and Cheshire Palliative Care Guidelines 2010*

Care of the Dying Patient – 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 **tota**l 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.

Care of the Dying Patient – Medication Guidance

# 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.

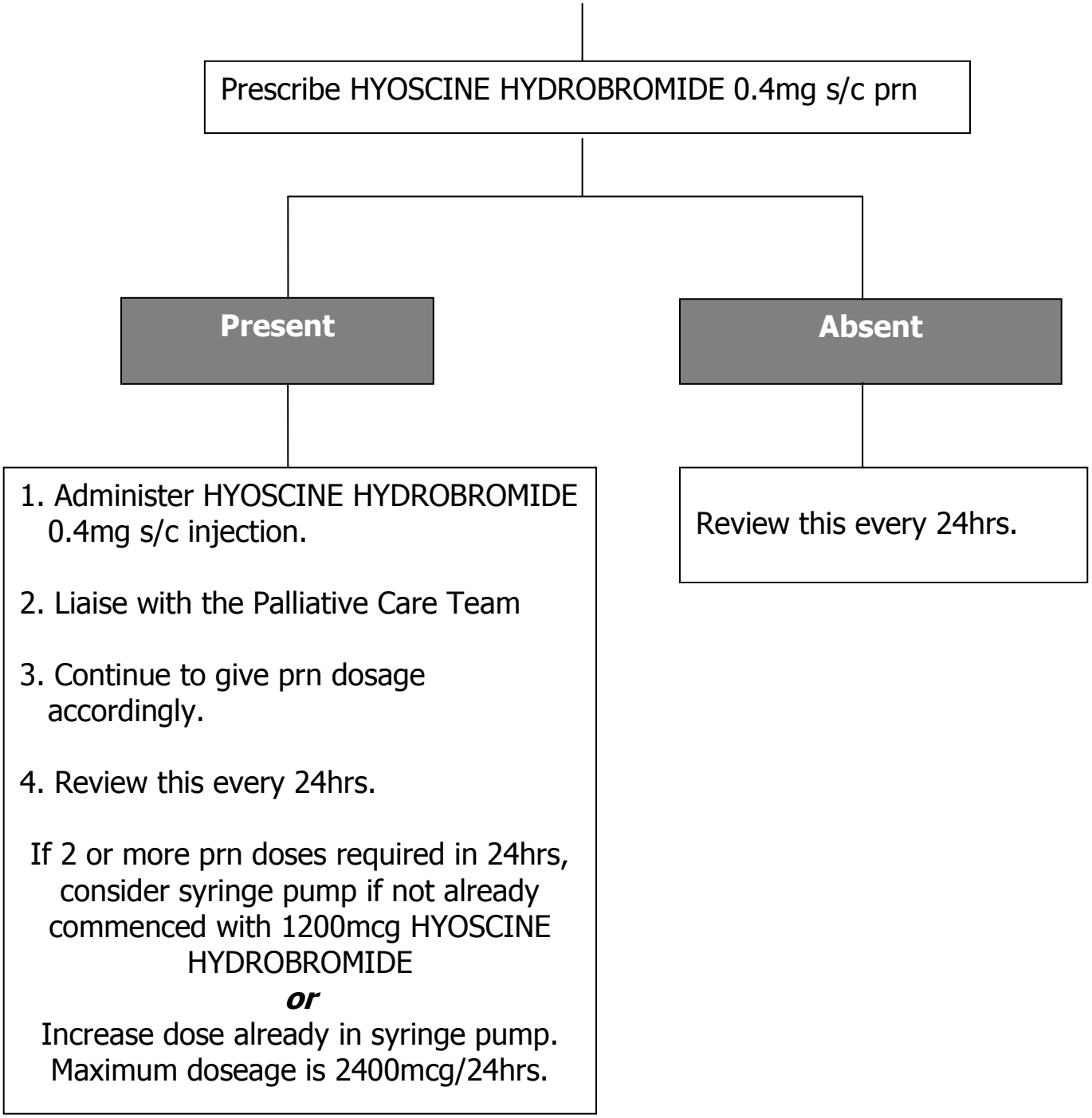
Doses via syringe pump should be titrated according to total 24hr PRN doses

**Absent**

Review this every 24hrs

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

# Respiratory tract secretions




- GLYCOPYRRONIUM 0.4mg 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.

Care of the Dying Patient – Medication Guidance

# 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

Consider an alternative antiemetic if previous one is not effective.

**Absent**

Review this every 24hours

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

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

Care of the Dying Patient – Medication Guidance

# 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

- 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.

# Remember

1. Recognise deterioration in a patient – could this be a sign that they are dying?

2. Keep the patient / family informed of any changes in care.

3. Prescribe anticipatory medication - convert oral to s/c medication.

4. 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.

5. Assess and monitor symptoms as they occur.

6. Control symptoms with prescribed medication.

7. Consider a syringe pump - discuss as far as possible the reasoning with the patient, their relatives or carers.

8. 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).

9. If the patient has an Implantable Cardioverter Defibrilator (ICD), contact the patient's cardiologist. Refer to ECG technician and to local guidelines re deactivating it.

10. Anticipate and be prepared for any specific religious, spiritual or cultural needs a patient might have.

11. If the patient is an Insulin Dependent Diabetic, contact Diabetes CNS for further guidance.

12. 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**