LAST DAYS OF LIFE FOR ADULTS POLICY

	POLICY

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Approving Body	General Palliative and End of Life Care Committee		
Date Approved	14th October 2021		
For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**		
	YES	**NO**	**N/A**
	X		
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Target Audience	All Trust Medical, Nursing and Allied Health Care Professionals & Staff who care for people at the end of life		
Review Date	October 2024		
Sponsor (Position)	Chief Nurse		
Author (Position & Name)	End of Life Care Clinical Nurse Specialist, Melanie Butcher on behalf of Macmillan Trust Lead Cancer Nurse, Penny Tindall		
Lead Division/ Directorate	Corporate		
Lead Specialty/ Service/ Department	Nursing/ End of Life Care		
Position of Person able to provide Further Guidance/Information	Macmillan Trust Lead Cancer Nurse		

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
What to expect in the final days of life (patient information leaflet)	December 2020

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1.0 INTRODUCTION

'The new approach to last days of life focuses on giving compassionate care and is a move away from previous processes and protocols. It recognises that in many cases, enabling the individual to plan for death should start well before a person reaches the end of their life and should be an integral part of personalised and proactive care. The aim is to promote a stronger foundation for good care and a culture of compassion in the NHS and social care. The priorities put people and their families at the centre of decisions about treatment." Department of Health, (26 June 2014).

Caring for people who are close to death demands compassion, kindness and a skilled application of knowledge. The Leadership Alliance for the Care of Dying People published a document in June 2014 "Priorities for care: Duties and responsibilities for health and care Staff" which sets out Five Priorities for Care in the last few days and hours of life. It also sets out the Duties and Responsibilities of Health and Care Staff to ensure the Priorities are achieved when they are involved in the care of dying people. In addition, enabling people to have choices at the end of their life needs to become an integral component of advance care planning in any care setting, including acute Trusts (The Choice in End of Life Care Programme Board, (2015) What's Important to Me - a review of choice in End of Life care).

The Priorities are all equally important to achieving good care in the last few days and hours of life. Each supports the primary principle that individualised care must be provided according to the needs and wishes of the person.

This policy has been developed to meet the priorities of care and ensure that staff deliver high quality, patient centred, individualised care.

2.0 POLICY STATEMENT

The purpose of this Policy is to:

- Promote the delivery of last days of life care following the five key priorities which are:
    1. Recognise dying
    2. Communication
    3. Involve
    4. Support
    5. Plan & do
- Support safe and accountable practice when providing symptom relief for patients in the last days/hours of life.
- Clarify roles and responsibilities.

This policy applies to:

Staff group(s)

- All clinical staff need to follow/ implement the individualised care plan e.g. doctors, nurses, specialist nurses, therapy staff.

Clinical area(s)

- This document will be used by all adult in-patient wards; assessment areas; emergency department; ICCU
- All hospital sites: King's Mill Hospital; Mansfield Community Hospital; Newark Hospital.

Patient group(s)

- This document applies to all in-patient adults.

Exclusions

- Paediatric patients under 18 years of age
- Pregnant women under the care of the maternity services.

3.0 DEFINITIONS/ ABBREVIATIONS

Trust:	Sherwood Forest Hospitals NHS Foundation Trust
Staff:	All employers of the Trust including those managed by a third party on behalf of the Trust
'Syringe Pump':	A device used for administration of medication continuously by the subcutaneous route.
'Healthcare Professionals'/'Staff'	All employees of the Trust including those managed by a third party organisation on behalf of the Trust.
'Preferred place of care/ death' (PPC/D)	A preference stated by the patient
Advance Decision to Refuse Treatment	A decision to refuse a specific type of treatment at some time in the future.
Guide to treatment specific symptoms at end of life: anticipatory medication	A guideline for ensuring medication is available to manage symptoms as they arise and without delay.
Multi-Disciplinary Team (MDT):	The ward team which includes Consultants, doctors, nursing staff, physiotherapists, occupational therapists, social workers and other specialist services e.g. Specialist Palliative Care.
Independent Mental Capacity Advocate (IMCA):	The Independent Mental Capacity Advocate (IMCA) is a role created by the Mental Capacity Act 2005. A local council or NHS body has a duty to involve an IMCA when a vulnerable person who lacks mental capacity needs to make a decision about serious medical treatment, or an accommodation move. This could be an older person with dementia or a learning disability. The IMCA will help support the older person to make the decision, will represent their views and should act in the person's best interests.
Integrated Discharge Advisory Team (IDAT)	Integrated Discharge Advisory Team
Butterfly Symbol	A picture of a butterfly to signify that the patient is in the last days of life. The purpose is to ensure that any staff caring for the patient, including non-clinical staff, are aware of the need for sensitivity, respect & quiet, before entering the side room or bed space of the patient.
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment

4.0 ROLES AND RESPONSIBILITIES

Divisional General Managers, Service Line Managers, Matrons and Heads of Nursing
The responsibility for ensuring that the policy is followed within areas is with both Clinical Leads and Heads of Nursing to:

- ensure that staff are released to attend training
- ensure that staff have access to the Last Days of Life supporting documentation.

Line Managers

- To ensure that staff access training and attend mandatory training.

All Healthcare Professionals

- Will attend training sessions and complete mandatory workbook.
- Have a responsibility for achieving good care in the last few days and hours of life through the following principles:
  - The possibility [that a person may die within the next few days or hours] is **recognised** and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.
  - Sensitive **communication** takes place between staff and the dying person, and those identified as important to them.
  - The dying person, and those identified as important to them, are **involved** in decisions about treatment and care to the extent that the dying person wants.
  - The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible to ensure **support**.
  - An individual **plan** of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

5.0 APPROVAL

This policy has been discussed and any amendments agreed at the General Palliative and End of Life Care Committee on 14th October 2021.

6.0 DOCUMENT REQUIREMENTS

This Policy follows the five key Priorities set out by the Leadership Alliance for the Care of Dying People published in June 2014, which are:

1. Recognise dying
2. Communication
3. Involve
4. Support
5. Plan and do.

The Priorities for Care reinforce that the focus for care in the last few days and hours of life must be the person who is dying. They are all equally important to achieving good care in the last days and hours of life. Each supports the primary principle that individual care must be provided according to the needs and wishes of the dying person. To this end the Priorities are set out in sequential order.

6.1 Recognise

- Initiating a decision regarding recognising the person is nearing the end of life must be part of an MDT discussion which could be at the board round, ward round, MDT meeting or routine assessment. The conclusion of this discussion must be documented in the medical notes. The person whose condition has deteriorated unexpectedly must be assessed as nearing the end of their life and expected to die in the next few days/hours

- Establish that the deterioration does not have a reversible cause, and/or further treatment is not desirable

- If potentially reversible, prompt action must be taken to attempt this, provided in accordance with the person's wishes (or best interests, if the patient lacks mental capacity)

- A management plan will be established and agreed following a Consultant/Senior Clinician led MDT discussion

- The goals of treatment and care, including the patient's preferred place of care and death, must be established, agreed with the patient, unless they have indicated that they do not wish to discuss this, and documented within the Last Days of Life Individualised Care Plan. Initiate the use of the 'butterfly symbol' – this needs discussion with the patient, if they are able, and their family to ensure that they understand the purpose of the symbol

6.2 Communicate

- An open and honest discussion with the patient about dying will take place in a sensitive and timely manner. This discussion must include an explanation of what is happening, why it is thought the person is dying, their wishes and preferences, likely prognosis and any clinical uncertainty. The discussion must be documented within the Last Days of Life Individualised Care Plan*(Where this discussion has not been held, the reasons must be clearly documented).*

- If the dying person chooses not to discuss this, their wishes should be respected but further opportunities to discuss should be offered.

- If the patient wishes, the same open and honest discussion about the patient dying should also take place with the relative/carer or those important to them, and documented. *(Where this discussion has not been held, the reasons must be documented within the Last Days of Life Individualised Care Plan). This is often most helpful as a joint discussion.*

- The patient will be fully informed about the management plan, if able. If the patient is not able to understand (e.g. due to lack of mental capacity or unconsciousness) this should be clearly documented within the Last Days of Life Individualised Care Plan.

- The relative/carer will be fully informed about the management plan, if consent is given by the patient.

- The person to contact from this point on and in the event of death is clearly established and with whom the person wishes their information to be shared. This must be clearly documented on page 1 of the Last Days of Life Individualised Care Plan

- The GP must be notified when the patient has died.

6.3 Involve

- If the patient has capacity to discuss their current preferences discussions must be offered to establish whether the person has an advance care plan:
    - Advance statement of wishes and preferences (including organ donation)
    - Advance Decision to Refuse Treatment
    - Lasting Power of Attorney for health and welfare decisions
    - ReSPECT document

- If there is no advance care plan in place, the opportunity must be offered for the person and their family to discuss their wishes, concerns, preferences to the extent that the person wants. This may include the patient's wish for direct release to the undertaker after death.

- If the person lacks capacity it is appropriate to elicit the views of the family and incorporate these into the overall Last Days of Life Individualised Care Plan.

- The Independent Mental Capacity Advocate (IMCA) is a role created by the Mental Capacity Act 2005. A local council or NHS body has a duty to involve an IMCA when a vulnerable person who lacks mental capacity needs to make a decision about serious medical treatment, or an accommodation move. This could be an older person with dementia or a learning disability. The IMCA will help support the older person to make the decision, will represent their views and should act in the person's best interests. An IMCA must be consulted if the dying person lacks capacity and has no family, carer or friends to ensure decisions have been made in their best interest.

- Discussions with the patient and/or family need to be had with regards to DNACPR decisions, as appropriate.

- A senior responsible clinician and registered nurse responsible for their care must be identified and communicated to the person and their family / those identified as important to them.

6.4 Support

- The needs and concerns of the family/those important to the patient must be acknowledged and actively assessed, explored, respected and met as far as possible (including any spiritual, religious or cultural needs).

- A referral to Specialist Palliative Care Team will be considered, if there are any complex pain or symptom management issues. The referral should be made via Call for Care **01623 781899 option 2.**

- Consideration will be made to arrange care in the patient's preferred place of care and refer to Integrated Discharge Advisory Team (IDAT) for Rapid Discharge Home to Die or Fast Track Discharge. It is the responsibility of the medical team to ensure that the Fast Track Continuing Healthcare Tool is completed.

- Wellbeing of the family or those important to the dying person must be considered. Staff must ensure that there is sufficient support available. This includes offering beverages, carer's comfort bags and overnight facilities to enable them to remain close to their loved ones. Car parking concessions are available for direct relatives. The spiritual wellbeing of the dying person and those who are important to them must be acknowledged. The Faith Centre is available to all faiths and provides facilities for prayer.

- Families and those important to the dying person may require additional support if the death has been unexpected. (e.g. understand how this impacts on the post mortem, coroners' and death certification procedures).

- The patient must be treated with respect and dignity whilst Care After Death procedures are being undertaken.

- The spiritual, religious and cultural needs of the deceased person must be respected and carried out according to their wishes.

- Universal precautions and infection risks are adhered to in accordance with local policy.

- The patient's property and valuables must be managed in accordance to the Safeguarding and Custody of Patients Property Policy. After death the patient's property and valuables may be given to the relative or labeled and stored for safe keeping family/those important to the patient to collect at an appropriate time.

- Bereavement leaflet and information regarding how and when to contact the Bereavement Centre to make an appointment - death certificate, patient's property where appropriate – must be given.

6.5 Plan and Do

- An individualised plan of care, which includes food and drink, symptom control and psychological, social, and spiritual support must be agreed, coordinated and delivered with compassion.

- Symptomatic management will be considered and anticipatory medications targeted at specific symptoms will be prescribed (see Appendix B)

- Nutrition and hydration will be considered. Diet and oral fluids are provided as tolerated and wished for. It is likely to be appropriate to stop intravenous fluids at this stage. If the patient is unable to swallow, decisions about clinically assisted hydration and nutrition must be in line with GMC guidance (see references) & relevant clinical guidelines e.g. NICE: NG31

- Implantable 'Cardiac Defibrillator (ICD) must be deactivated/not in situ

- Ensure section 4 (resuscitation status) of the ReSPECT form has been reviewed/completed

- The drug card has been reviewed, and non-essential medications will be stopped (for example antibiotics & medications for most chronic conditions)

- All inappropriate routine measurements of observations and routine blood tests will be discontinued.

6.6 Daily action review

A daily action review must be undertaken by a Senior Clinician or Senior Nurse and incorporate the following:

- Assess at an MDT daily if the patient is still in the last days of life.
- Record outcomes/changes to management plan within the Last Days of Life Individualised Care Plan
- Communicate daily with the patient and/or family regarding current management plan and on-going changes in condition and treatment
- Review anticipatory medications and if any adjustments are needed. (If reviewed by the Senior Nurse, then the on-call team will need to amend the medications)
- Consideration must be made when reviewing changes to the patient's preferred place of care when circumstances change. This may require support from the IDAT to provide a rapid discharge home to die if this is requested.

6.7 Supporting Documentation

The Last Days of Life Individualised Care Plan has been developed to enable good practice and facilitate the implementation of an individualised care plan for the last days of life.

Hard copy useable versions of the documentation should be ordered via Clinical Illustration.

6.7.1 Combined Medical and Nursing Last Days of Life Individualised Care Plan

The Last Days of Life Individualised Care Plan should be commenced as part of the individualised care planning process. This includes placing a Butterfly sticker (which comes with the Care Plan) into the Medical section of the patient's notes, to alert colleagues that the Last Days of Life Individualised Care Plan has commenced.

The Last Days of Life Individualised Care Plan contains pages to record 7 days of care. In instances where additional pages are required, a Continuation Sheet is available from Clinical Illustration. This must be inserted at the back of the Last Days of Life Individualised Care Plan, to ensure that a complete record of care is provided for the patient.

This process also includes the following:

For Medical Colleagues (complete the pink sections of the Last Days of Life Individualised Care Plan)

- Recognising dying and documenting of clinical decisions, including how the decision has been made and that this was MDT/Consultant led. Any reversible causes should be considered (Priority 1 – 'Recognise' section of the Last Days of Life Individualised Care Plan)
- Initial discussions with patient and family/carer regarding recognising dying and the initial management plan being documented
- Record the patient's wishes, preferences or any advance care plans, ADRT
- Preferred Place of Care (PPC)/death has been documented
- Symptom Management, including rationale for prescribing anticipatory medication and communication to the patient/those important to them
- A daily medical review will include the assessment of any changes in condition and recognition that the person is still deemed to be in the last days of life; a review of the anticipatory medications and adjustments made; a review of the PPC may be appropriate at this stage. Any discussions that have taken place with the dying person or those important to them should be clearly documented
- When the patient dies, the verification of adult death and cause of death should be clearly documented , within the Last Days of Life Individualised Care Plan.

For Nursing Colleagues (complete the lilac sections of the Last Days of Life Individualised Care Plan):

The Last Days of Life Individualised Care Plan includes the following:

- Confirming a management plan has been established
- Completion of the following sections:
  - Priority 2 – Communication
  - Priority 3 – Involve
  - Priority 4 – Support
  - Priority 5 – Plan and Do

Baseline Assessment

The baseline assessment consists of a number of areas to be considered when establishing the level of a patient's individual needs. This enables the nurse to tailor the Last Days of Life Individualised Care Plan (under Priority 5 – Plan and Do). For example this will include the following:

- Mouth care
- Fluids and nutrition
- Personal hygiene
- Skin integrity
- Bladder management
- Bowel management
- Symptom Management.

On-going Nursing Assessment
The on-going nursing assessment follows the action rationale process of delivering care. The on-going assessment of identified problems and evaluation of interventions will be undertaken in relation to the patient's needs. This may be required as frequently as 2 hourly but no longer than 4 hourly intervals.

The on-going assessments will record if the patients' needs are being achieved; any changes in condition must be documented within the Last Days of Life Individualised Care Plan. At the end of a period of care delivery there will also include a summary of the patient's status throughout that day or night.

Record of Communication Sheet
Any conversations or concerns shared by the patient and those important to them must be recorded within the Last Days of Life Individualised Care Plan.

Care After Death
Ensure a copy of the 'Information for those who are bereaved' leaflet is given to the family/those important to the patient, prior to leaving the Ward. (Copies of the leaflet are available from the Bereavement Centre).

The 'care of the person after death' section takes into account information about the patient's death, personal care of the deceased, relatives information needs such as Bereavement Services, and organisation information. **This section must be completed in a timely manner.**

6.8 Butterfly Symbol

The purpose of the butterfly symbol is to alert all staff that a patient is entering the last days/hours of life. This will prompt staff to approach the patient and relatives/carers in a sensitive and thoughtful manner. An explanation of the symbol should be given to the family and those important to the patient.
If the patient/family are in agreement, the symbol may be attached to the door of the cubicle or the bedside screens if the patient is being nursed in the ward bay areas. This also applies to the cubicles and ward areas within the Emergency Department and Emergency Assessment Unit.

6.9 Patient/Carer Information

Information Leaflets are available for family/those important to the patient, as follows:

- What to Expect in the Final Days of Life
- Information for those who are bereaved
- Guide for Compassionate Visiting at Sherwood Forest Hospitals during the Covid-19 Pandemic, for End of Life Care (available from Clinical Illustration)

The following support resources are available for family/those important to the patient from the End of Life Care Team and Community Involvement Hub:

- Comfort Bags (including a selection of toiletries, refreshments, notebook/pen, etc)
- Free parking passes
- Butterfly Bags (including a T-light candle, wooden hearts, etc).

Additional faith/spiritual resources are available from the Faith Centre, extension number 3047.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (e.g. verbal, formal report etc) and by who)
A review of all incidents involving Last days of Life	Divisional Leads	Incidents will be notified via the Trust's Datix incident reporting procedure and assessed to ensure that appropriate actions are taken to reduce the identified risks.	As and when they occur	SFHFT General Palliative & End of Life Care Committee
Where several incidents occur, these will be investigated to identify the root cause.	Policy Lead	Incidents will be notified via the Trust's Datix incident reporting procedure and assessed to ensure that appropriate actions are taken to reduce the identified risks.	As and when they occur	SFHFT General Palliative & End of Life Care Committee
– see below				
Last Days of Life Individualised Care Plan review	End of Life Care Team	Audit	As and when they occur	SFHFT General Palliative & End of Life Care Committee
The individual practitioners will be expected to audit their own clinical practice	The individual practitioners	Audit	Annually	The individual practitioner's appraisal

8.0 TRAINING AND IMPLEMENTATION

Staff who are involved in care of the dying patient should take every opportunity to access the relevant training and education for end of life care to support their practice.

The following training and education sessions will be delivered by the End of Life Care Team to support good practice and implementation of this Policy.

- Annual Mandatory Workbook for all nursing, midwifery and allied health care professionals
- Induction for all health care professionals
- End of Life Care Champions Network, including bi-monthly meetings
- Access to the 'End of Life Care Support Training' e-learning package on Sherwood e-Academy (Trust Intranet site).

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix A.

- This document is not subject to an Environmental Impact Assessment

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- Leadership Alliance for the Care of Dying People (June 2014): *One chance to get it right Improving people's experience of care in the last few days and hours of life*. Publications Gateway Reference 01509 - One Chance to get it right (publishing.service.gov.uk)
- General Medical Council (2010): *Treatment and care towards the end of life: good practice in decision-making*. *Guidance for Doctors.* GMC/EOL/0510 - Treatment_and_care_towards_the_end_of_life___English_1015.pdf_48902105.pdf (gmc-uk.org)
- Mental Capacity Act (2005) http://www.legislation.gov.uk/ukpga/2005/9/contents
- NICE Care of dying adults in last days of life (2015) – NICE Guideline NG31- Overview | Care of dying adults in the last days of life | Guidance | NICE
- NICE Quality Standard (QS13) End of Life Care for Adults (November 2011, updated September 2021) - Update information | End of life care for adults | Quality standards | NICE
- Ambitions for Palliative and End of Life Care (2021-2026) (Refreshed May 2021)
- Sherwood Forest Hospitals Foundation Trust EOLC Strategy (2016-2020)
- What's important to me: A review of choice in End of Life Care, The Choice in End of Life Care Programme Board, (2015)
- Our commitment to End of life care; 'What's important to me publication' Department of Health (2016) - Our commitment to you for end of life care: the government response to the review of choice in end of life care (publishing.service.gov.uk)
- The Mid Nottinghamshire Better & Together Alliance - End of Life Together service (2018)

- Talking about dying: How to begin honest conversations about what lies ahead. Royal College of Physicians (2018) - Talking about dying: How to begin honest conversations about what lies ahead | RCP London
- Palliative Network Guidelines (2016) - Palliative Care Guidelines Plus (pallcare.info)
- Nottinghamshire Guidance for End of Life: Nottinghamshire-Guidance-for-Care-in-the-last-year-of-Life-2020.pdf (eolcare.uk)

Related SFHFT Documents:

- ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) Policy
- T34 Syringe Pump Procedures for Adult Patients (accessed via Marsden Manual)
- Discharge Policy
- Care After Death Policy – including procedure for the direct release of a deceased patient
- Safeguarding and Custody of Patients Property Policy
- Verification of an Expected Adult Death by Registered Nurses Policy
- Car Parking Policy.

11.0 KEYWORDS

LCP; die; dying; death; End of Life; Palliative Care; and; Priorities of Care

12.0 APPENDICES

Appendix A – Equality Impact Assessment
Appendix B – Guide to treatment of specific symptoms in the last days/hours of life

APPENDIX A - EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: LAST DAYS OF LIFE FOR ADULTS POLICY			
New or existing service/policy/procedure: Existing			
Date of Assessment: 24/12/2018; reviewed on 20th September 2021			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	None	Not applicable	None
Gender	None	Not applicable	None
Age	None	Not applicable	None
Religion	None	Not applicable	None
Disability	None	Not applicable	None
Sexuality	None	Not applicable	None
Pregnancy and Maternity	None	Not applicable	None
Gender Reassignment	None	Not applicable	None
Marriage and Civil Partnership	None	Not applicable	None

Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	None	Not applicable	None

What consultation with protected characteristic groups including patient groups have you carried out?

- **N/A**

What data or information did you use in support of this EqIA?

- **N/A**

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

- **No**

Level of impact

From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact:

Low Level of Impact

Name of Responsible Person undertaking this assessment:
Reviewed by Mel Butcher, EoLC Clinical Nurse Specialist

Signature:

Date:
Reviewed on 20th September 2021

Appendix B: Guide to treatment of specific symptoms in the last days/hours of life

1. Pain

If the patient is opioid naïve, prescribe 2.5–5 mg Morphine SC PRN (hourly). If 2 or more doses are required in 24 hours start Morphine by continuous subcutaneous infusion (CSCI) over 24 hours according to the number of PRN doses required. If the oral route is available, 5 mg Oramorph STAT and PRN is an alternative.

If the patient is already on oral Morphine, calculate the subcutaneous equivalent daily dose (total daily dose divided by 2), and prescribe one sixth of this as the PRN dose. **NB** The dose calculation is different for other opioids opioids (see www.book.pallcare.info for dose conversions).

Review the CSCI dose daily and consider increasing this to include and additional PRN doses given.

Dosing example: Total daily dose Morphine PO is 30 mg. Subcutaneously, the equivalent is 15 mg. The PRN dose is one sixth of this (2.5 mg).

If patient is on an alternative opioid such as Oxycodone or Fentanyl, or is sensitive to Morphine, see www.book.pallcare.info. Dose conversion: Morphine 10mg oral = Morphine 5mg SC. Morphine 5mg SC = Fentanyl 0.1 mg or 100 micrograms SC.

Fentanyl is a strong opioid which can be used as an alternative to Morphine and Oxycodone with Specialist Palliative Care advice. It is VERY POTENT and short acting, about 1 hour. Its main place in therapy is in patients with renal and hepatic impairment, as dose adjustment is not normally required. Consider use if eGFR is less than 30 ml/min or has factors of severe hepatic impairment (PT >130% of normal, platelets <150 x 10^9/L, bilirubin >100 micromol/L, severe cirrhosis (Child-Pugh C), ascites, hepatic encephalopathy, hyponatraemia, concurrent moderate renal impairment).

Starting dose: For example, if a patient is opioid naïve a suitable starting dose of Fentanyl is 12.5 – 25 micrograms SC PRN 1 hourly. If any PRNs are used in 24 hours commence a CSCI over 24 hours according to the number of PRN doses used. **Contact the Specialist Palliative Care team for advice before prescribing via Call for Care (01623781899).**

The opioid dose converter on the PANG guideline site www.book.pallcare.info is helpful to check conversion doses. At higher doses use conversions cautiously and monitor closely to avoid toxicity.

2. Dyspnoea

Consider causes of dyspnoea and treat appropriately (eg hypoxia, pulmonary oedema, respiratory tract secretions, bronchospasm).

Non-drug management – e.g. explanation, reassurance, repositioning, fan, relaxation.

If non-pharmacological treatments are ineffective, try Morphine 2.5 mg SC PRN or Midazolam 2.5 mg SC PRN.
If more than 2 doses in last 24 hours, combine subcutaneous doses in to a CSCI over 24 hours, and continue PRN prescription.

NB: PRN Morphine dose should be one sixth of total daily dose.

3. Nausea and Vomiting

Continue any orally effective agents parenterally, for example: Cyclizine 50 mg TDS PO = Cyclizine 75 mg / 24h by syringe pump.

Metoclopramide 10 mg TDS PO = Metoclopramide 30 mg / 24 hours by CSCI

If no prescription exists, prescribe Levomepromazine 6.25 mg SC PRN (hourly)

If more than 2 PRN doses in 24 hours, add to CSCI: Levomepromazine 12.5 mg / 24 hours and continue PRN prescription.

If more than 2 PRN doses in the subsequent 24 hours, increase CSCI prescription to Levomepromazine 25 mg / 24 hours.

If you are requiring more than Levomepromazine 25 mg / 24 hours to control nausea and vomiting, please discuss with Specialist Palliative Care (C4C 01623 781299) and request review.

4. Respiratory Tract Secretions

Explain to the patient's relatives that noisy breathing is due to the inability of the patient to clear secretions, and that they are not choking.

Try repositioning the patient.

Prescribe Hyoscine Butylbromide 20 mg SC (hourly) and administer if non-pharmacological methods ineffective. If any doses are used commence a CSCI of Hyoscine Butylbromide 40 – 60 mg / 24h.

Continue to give PRN doses as required.
If symptoms persist beyond 24 hours, increase the dose to 120 mg / 24 hours.

5. Agitation and Delirium

Consider treatable causes – for example increased pain, urinary retention and faecal impaction.

Prescribe Midazolam 2.5 – 5 mg SC PRN (hourly). Consider adding Levomepromazine 6.25 – 12.5 mg SC PRN (hourly) as second line.

If more than 2 PRN doses in 24 hours add respective doses to CSCI.

Written in line with Nottinghamshire Guidance for End of Life: Nottinghamshire-Guidance-for-Care-in-the-last-year-of-Life-2020.pdf (eolcare.uk)