QUICK GUIDE	CARE IN THE LAST WEEKS OR DAYS OF LIFE

FIVE KEY PRIORITIES

RECOGNISE:

- The possibility that a person is in the last weeks of life or they may die within the next few days or hours and communicate this clearly:
- Consider and address reversible causes where appropriate / possible
- Identify and where possible make decisions in accordance with the individual's wishes and needs
- Review the assessment and decisions on a regular basis

COMMUNICATE:

- Sensitively with the individual and those important to them

INVOLVE:

- All relevant people in making decisions as far as they indicate they want to be

SUPPORT:

- The family and other people important to the dying person by exploring, respecting and meeting their needs where possible

PLAN:

- Create an individualised plan of care. This should include decisions around:
  - Cardiopulmonary resuscitation
  - Facilitating or preventing change in place of care
  - Supporting oral food and fluid intake
  - Stopping or continuing physical observations and / or investigations
  - Starting, stopping or continuing clinically assisted hydration and / or nutrition
  - Review of long term medication - stop those no longer needed; switch others to a route which ensures they continue and provide benefit
  - Anticipatory prescribing of medication for the common symptoms at end of life (i.e. pain, breathlessness, respiratory tract secretions, agitation, nausea and vomiting) and other problems specific to that individual, such as management of seizures or bleeding, etc.
  - Review ICD / Ventilation

QUICK GUIDE	DIABETES MANAGEMENT IN THE LAST WEEKS OF LIFE
Reference	Diabetes UK (2018) End of Life Diabetes Care: Clinical Care recommendations. For full algorithm please follow link www.diabetes.org.uk/resources-s3/2018-03/EoL_Guidance_2018_Final.pdf - (page 023)

Assessment/Description

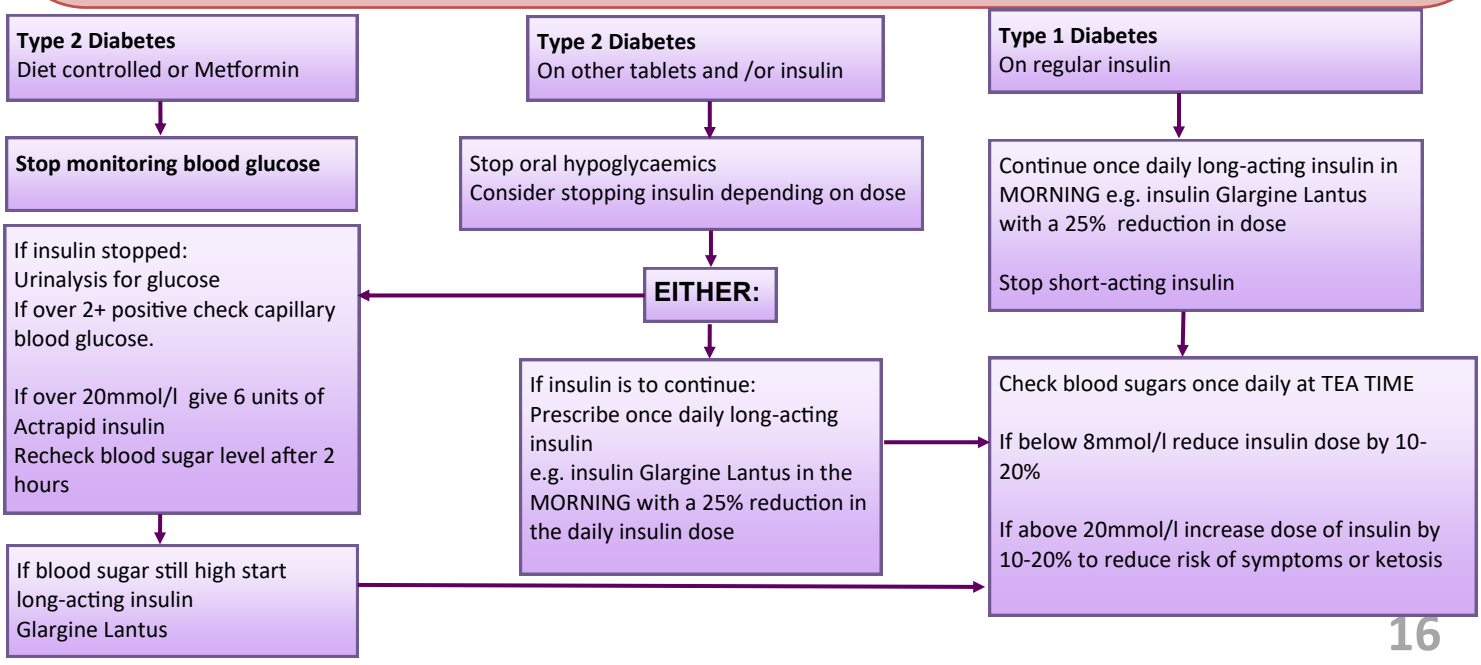
Explore with the individual and those important to them changing the approach to diabetes management including:

- The aim of management - avoiding hypoglycaemia rather than avoiding longer term complications due to hyperglycaemia
- The value of continuing to monitor blood glucose readings
- The method and frequency of checking blood glucose levels
- The type of management - tablets and / or insulin

Devise a management plan with the patient and those important to them. Ensure your local diabetes specialist team are involved if the patient remains on insulin. Aim to:

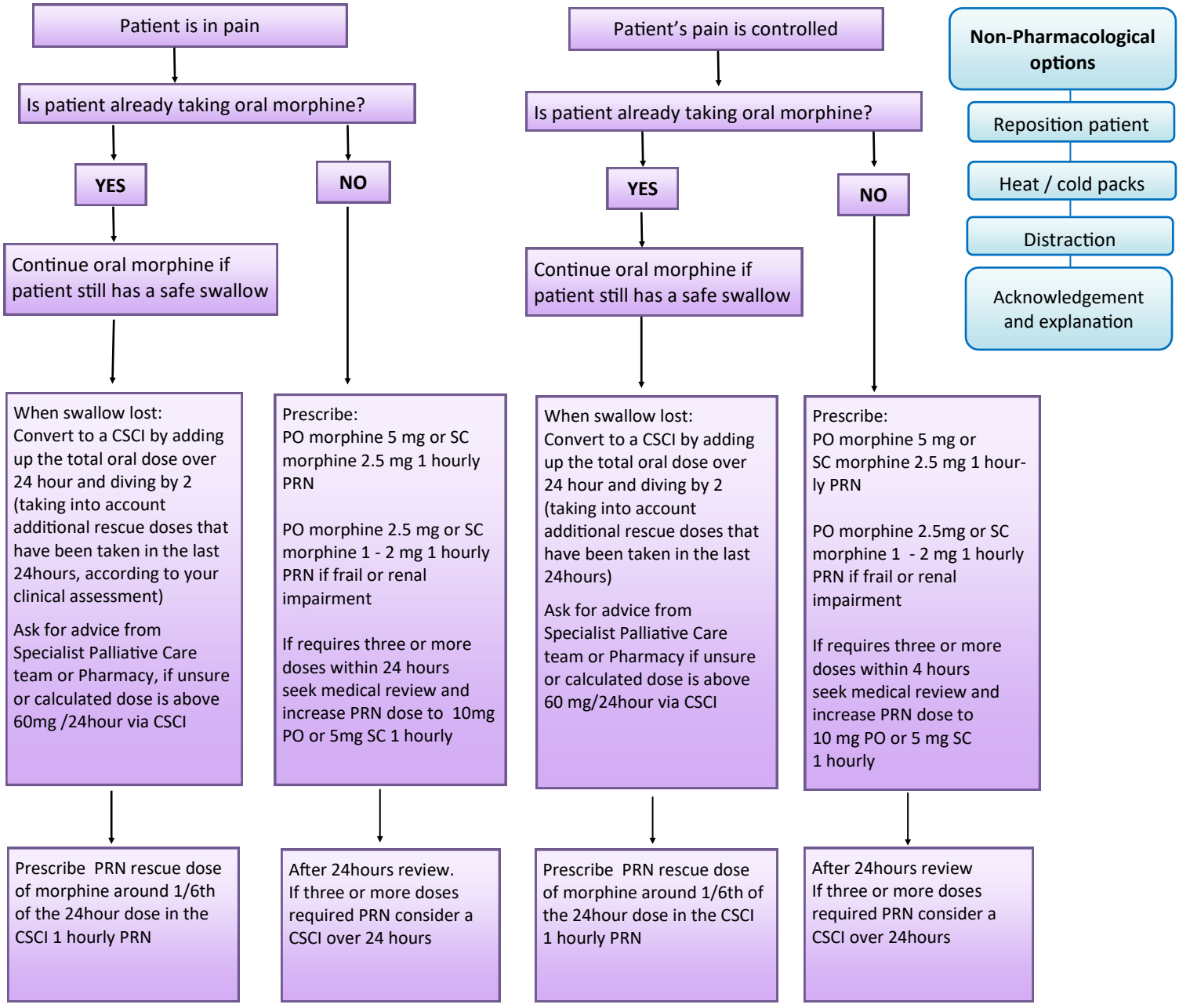
- Keep invasive tests to a minimum
- Be alert to symptoms that may be due to hypo or hyperglycaemia and have appropriate medication / interventions available to address these if they develop

AIM for a Target BM reading between 6 and 15.



GENERAL COMMENTS

In the majority of cases injectable morphine is the first line opioid of choice in the last days of life.
If patient has been well established on an alternative opioid such as Oxycodone continue it and follow the principles outlined in the flow diagrams.
For patients who have not previously been given medicines for pain management, start with the lowest effective dose of pain killer and titrate as clinically indicated.
Alternative opioids may be needed if the patient has significant renal impairment - seek specialist advice.



ADDITIONAL INFORMATION

Transdermal opioid patches at end of life (Fentanyl /Buprenorphine)

It is recommended that opioid patches are left in place and changed as usual in last days of life
If pain occurs a rescue dose of an appropriate oral or injectable opioid is administered—see page 8 for guidance about equivalent doses.
If 2 or more rescue doses are needed in 24hours consider setting up a CSCI with the total dose of rescue medication given in the previous 24 hours up to a maximum of 50% of the existing regular opioid (patch) dose.
Remember to combine the dose of the opioid patch and the dose of opioid in the CSCI to work out the new rescue dose (roughly 1/6th of the total 24hour dose)

IF YOU ARE IN ANY DOUBT ABOUT HOW TO MANAGE A PATIENT'S PAIN IN THE LAST DAYS OF LIFE ASK FOR SPECIALIST ADVICE

QUICK GUIDE | NAUSEA AND VOMITING IN THE LAST DAYS OF LIFE

Assessment/Description
Patient complains of nausea, or is vomiting

Pharmacological Options:

INITIALLY → Levomepromazine 2.5 - 6.25 mg SC 6 hourly PRN (max dose 25 mg / 24 hours). Lower dose may avoid undue sedation in some patients.
See below for alternative anti-emetics.

ONGOING → Continue to use Levomepromazine 2.5 - 6.25 mg SC PRN 6 hourly
Review dosage after 24 hours.
If 2 or more doses given consider a CSCI with 6.25 -12.5 mg over 24 hours.

Alternative anti-emetics include:
- Haloperidol 500 micrograms - 1.5 mg SC PRN 8 hourly (max dose 5mg / 24 hours)
- Cyclizine 50 mg SC PRN 8 hourly (max dose 150 mg / 24 hours)
- Buccastem 3 - 6 mg BD

Nausea and vomiting can be complex to manage - if patient is not settling seek specialist advice.

Raised intracranial pressure due to brain metastases may cause nausea and/or vomiting that might respond to high dose steroids (3.3mgs - 6.6mgs dexamethasone SC OD).

Non-Pharmacological options

- Reposition patient
- Eliminate known precipitants / strong odours
- Acknowledgement and explanation

QUICK GUIDE | BREATHLESSNESS IN THE LAST DAYS OF LIFE

Assessment/Description
Breathlessness can be really frightening. If heart failure is a contributing factor consider a trial of a diuretic via a suitable route. Only use oxygen if patient has been shown to be hypoxic. At the end of life, the aim is for comfort, not to maintain oxygen saturations.
Low doses of opioids are helpful in relieving breathlessness and evidence shows they are better given by continuous infusion (or MR oral medication), than PRN or regular stats. However, opioids can be trialled on a PRN basis and given as a stat dose if a patient is distressed'

Pharmacological Options:

INITIALLY: → If patient not on an opioid regularly:
Morphine 2.5 mg SC 4 hourly PRN. Or 2.5 - 5 mg PO 4 hourly PRN if safe swallow.

ONGOING: → If tolerated, start a CSCI with morphine sulfate 5 -10 mg over 24 hours; alternative opiates e.g. oxycodone can be used as appropriate (seek specialist advice if unsure).

If there is associated anxiety and fear, benzodiazepines such a lorazepam and midazolam can be helpful. Midazolam can be added to the CSCI if required. Sometimes doses as low as 5 mg/24hrs can be helpful. Other patients may require more, and it is essential that we recognise the priority to relieve distress and suffering in patients who are imminently dying, in a proportionate but effective manner.

ONGOING: → Breakthrough doses can be prescribed, such as morphine 2.5 - 5 mg SC PRN 1 hourly and midazolam 2.5 - 5 mg SC PRN 1 hourly.
Seek specialist advice if symptoms remain challenging.

Non-Pharmacological options

- Reposition patient- Sit up / lean forward
- Reassurance and explanation
- Gentle air flow with fan / open window
- Regular mouth care

QUICK GUIDE | RESPIRATORY TRACT SECRETIONS IN THE LAST DAYS OF LIFE

Assessment/Description

At the end of life, people may struggle to clear secretions from their upper airways. This is normal, is usually a sign of diminished consciousness, and many patients will be unaware. Such secretions can make breathing noisy. Acknowledgement and explanation of these noises to those present is important. Sometimes repositioning a patient may help. A pharmacological intervention may not always be necessary. However, it is worth remembering that treating early is often more successful, and medications will not remove existing secretions. Decisions to treat with medication involve the balance of these elements, and should centre around good communication, and an assessment of the discomfort and distress caused to the patient, and to those around them.

Pharmacological Options:

INITIALLY:

Glycopyrronium 200 micrograms SC PRN 1 hourly
or (alternative) hyoscine butylbromide 20 mg SC PRN 1 hourly
Third line option: Hyoscine Hydrobromide 400micrograms SC PRN 1 hourly

ONGOING:

Anti-cholinergics	Dose Range via CSCI/24 hours
Glycopyrronium	600 micrograms to 1.2mg
Hyoscine butylbromide	60mg to 240mg
Hyoscine hydrobromide	1.2mg to 2.4mg (causes sedation)

In significant renal impairment use Glycopyrronium
Seek Specialist Palliative Care advice if patient not settling

- Anti-cholinergic side effects can arise: treat this with frequent mouth care which may include artificial saliva replacement gels or sprays.
- If one agent doesn't work, try switching to the other after full titration to maximum dose over 24 hours; if there is still no improvement, consider stopping medication.
- Seek Specialist advice as required.
- **Hyoscine hydrobromide crosses the blood brain barrier and causes sedation.**

Non-Pharmacological options

- Reposition patient
- Active surveillance
- Acknowledgement and explanation

QUICK GUIDE | AGITATION / TERMINAL RESTLESSNESS IN THE LAST DAYS OF LIFE

Assessment/Description

Look for any reversible cause of agitation, such as urinary retention, constipation, pain or fever and, if identified, institute appropriate management plans, (e.g. catheter, enema, analgesia, anti-pyretic PR if not swallowing).

Consider, and where possible, address physical, psychological and spiritual factors as well as environmental factors such as light and noise.

Pharmacological Options:

INITIALLY:

Midazolam 2.5mg - 5 mgs SC up to 1 hourly PRN
If eGFR < 30 consider giving a reduced dose of midazolam, e.g. 1 mg - 2.5 mg SC PRN 1 hourly

DELIRIOUS:

Consider Haloperidol 0.5—1.5 mg SC 2 hourly PRN or
Levomepromazine 6.25mg SC 2 hourly PRN (monitor for extrapyramidal side effects)

If 2 or more doses of medication required to settle the patient in a 24hour period consider setting up a continuous subcutaneous infusion (CSCI)

ONGOING:

Agitation	Dose Range via CSCI/24 hours
Midazolam for agitation	up to 30 mg
Haloperidol for agitation	up to 5 mg
Levomepromazine	up to 25 mg

Seek Specialist Palliative Care advice if doses above 30 mg of midazolam, 5 mg of haloperidol or 25mg of levomepromazine are needed.