



All Wales Guidance: Care Decisions for the Last Days of Life

Version 12 May 2023

**An evidence based good practice guide
to support healthcare professionals delivering individualised holistic
care to those in the last days and hours of life**

This document forms part of the patient's confidential clinical record

Important note:

If the patient is **NOT** in the last days or hours of life, Care Decisions Guidance should **NOT** be used.

The full set of All Wales Care Decisions Guidance v12 consists of:

Document A - Main Care Decisions Guidance document (4 pages)
Document B - Patient Symptom Assessment Chart (SEWS)
Document C - Community PRN Medication Administration Record
Document D - Individual Case Review sheet (for evidencing care provided)
Document E - Symptom Control Guidance

Additional Care Decisions Supplements and Appendix are available:

- Covid-19 Symptom Control Supplement
- Diabetes Management Supplement
- Appendix: Considering diversity in delivering person-centred care



Care Decisions for the Last Days of Life

Context of the All Wales Care Decisions Guidance (CDG):

- **Delivering the best care in the last days (or hours) of life is everybody's business.** People in Wales die in many different places: in acute or community hospitals; in their own, a relative or friend's home; in residential or nursing care homes; in hospices, prisons etc. There is an equal need to deliver the best care possible, whatever the setting. The main 4 page Guidance document (Document A) leads you through the important points to consider for each individual person. The aim is to support and empower you, as a healthcare professional, no matter what your role or specialism, to be able to deliver high quality care in the last days of life. Where further support or advice is needed, specialist palliative care services (including out of hours) are available 24/7 within each Health Board area across Wales.
- The CDG reflects the need for **individualised person-centred care**. CDG advocates that every opportunity should be taken to discuss, with the dying person (where clinically possible) and with those important to them, care preferences, needs, goals and wishes, as well as to make shared decisions about their care.
- The **CDG is evidence based good practice guidance** developed, regularly reviewed and updated by specialists in Wales. (NICE guidance: Care of dying adults in the last days of life, NG31 (2015); The Five Priorities of Care: Leadership Alliance Care of the Dying Patient, One Chance to get it Right Report (2014)).

Targeted use:

- This guidance applies to **adults where death is anticipated or expected in the next few days or hours**.

Prior to commencing guidance use:

- **It is recommended that, wherever possible, medical and nursing staff should carry out a joint clinical assessment. A senior clinician should be involved in initial decision-making.**
- The term 'patient' is used for ease, but represents people dying in all settings.

General points:

- The Main 4 page Guidance (Document A) can be used with the other Care Decisions supporting documents (e.g. Symptom Control Guidance, Symptom Assessment Chart) as required.
- Prescribe all medications in the appropriate prescription charts, as used locally.
- Completing the Main Guidance document can act as an effective communication tool for teams and can prevent duplication of work such as repeated conversations, which may be distressing for patients. If discussions, decisions and the care given are not recorded in the Guidance (or elsewhere) there is **no evidence or record** that these took place. Using the Guidance can also show that you are working together as a staff team, demonstrating respect and that a person's dignity and wishes are taken seriously.
- People's needs and wishes e.g. beliefs, preferred language, can change when they know they are dying.
- The CDG 'Considering Diversity Appendix' can help guide you further in delivering person-centred care.
- Complete and return a Case Review sheet for all patients. This also evidences the care given.

Using the Main Guidance Document A:

- The Main Guidance document acts as a prompt to support and guide you to deliver the best care possible. It does not replace clinical judgement. Summarise the priorities and decisions of the patient, those important to them and the clinical team in the relevant sections. Briefly document the agreed individual plan of care and, if needed, write more fully in the patient's clinical record. Record all further decisions and progress in the patient's clinical record.
- This document should be filed in the current section of the patient's clinical record.

Who should complete what sections of the main Guidance document:

- Individual teams should agree which particular sections are completed by doctors or nurses depending on their local circumstances. **Identify the responsible clinician (consultant/GP) and the senior clinical decision maker consulted at the time of completing the document.**

Name:

Date of Birth:

Address:

NHS Number:



All Wales Guidance: Care Decisions for the Last Days of Life

This document forms part of the patient's confidential clinical record. (See context for its use on the previous page.)
Mae'r ddogfen hon ar gael yn y Gymraeg hefyd. / This document is also available in Welsh.

Clinical assessment:

Do the clinical team agree that the patient is in the last days of life? Yes No

Document changes that make the team think that this person is now dying:

Important:

If the patient is **NOT** in the last days of life, Care Decisions Guidance should **NOT** be used - see page 4.

Have reversible causes of deterioration been considered? Yes No

Comments:

What is the main medical condition likely to be responsible for this deterioration?

Person centred focus - patient understanding and priorities:

Patients should be given opportunities to discuss and plan their individualised care.

Is the patient aware that they are deemed to be in the last days of life? Yes No OR
 Patient is unable (for clinical reason) to discuss* Patient states they do not want to discuss*

Document any discussions with the patient about their awareness of dying (so others can build on/avoid duplication).

Record what matters most to them including any priorities, needs or concerns they have/are known to have had, taking into account their capacity to make decisions. *

**Involve and discuss, as appropriate, with those important to the patient – see page 4*

Important holistic information about the patient:

Note any key medical, nursing, social or other important information which may affect, or needs to be taken into account, when providing individual patient care. These may include: disability e.g. hearing, sight, mobility; language; race, culture, religion and belief; sexual orientation; gender identity, their important relationships; anxiety, mental health; and any caring roles they usually undertake. *For more practical guidance about these see the Care Decisions 'Considering Diversity Appendix'.*

NB It is statutory duty that Welsh speakers are enabled to speak their mother tongue. Welsh language preferred

Patient's preferred place of care:

Where is the preferred place of care for this patient in the last days of life?

Is this currently being achieved? Yes No No preference or unable to express

If no, why not?

Name:
 Date of Birth:
 Address:
 NHS Number:

Responsible consultant / GP
 Completing HCP (initials)
 Date

Advance Care Planning (ACP) and Future Care Planning (FCP): *Refer to national/local guidance*

Has the patient expressed wishes and preferences in an Advance Care Plan? Yes No Don't know
 If yes, how have these views been taken into account?

Has the patient completed an Advance Decision to Refuse Treatment (ADRT)? Yes No Don't know
 Is there a registered Lasting Power of Attorney (LPA) for Health and Welfare? Yes No Don't know
 Is there a Future Care Plan (FCP) in place? Yes No Don't know

Has the patient expressed a decision on the organ donor register? (Can check on: 03000 20 30 40) Yes No
 Has the patient opted in or opted out or have they nominated an appointed representative ?
 If the patient **hasn't opted out** please discuss tissue donation with patient / next of kin. If tissue donation is a possibility please refer to national Referral Centre for tissue donation on 0800 432 0559.
 Action:

Medical management plan:

Document agreed medical management plan, particularly with regard to ACP/FCP, further investigations, escalation of care and interventions which may be considered.

Hydration decisions:

Document any discussions and decisions regarding hydration (including the risk/benefit of oral fluids and/or the use of parenteral fluids) with the patient / those important to them.

Nutrition decisions:

Document any discussions and decisions about nutrition (including artificial feeding via PEG/NG tube) with the patient / those important to them.

CPR Status – Natural Anticipated and Accepted Death (NAAD): *Refer to All-Wales DNACPR policy*

Document any discussion with patient and those important to them about allowing natural death to occur, and complete appropriate forms (refer to fuller entries in patient record if necessary).

Name:
Date of Birth:
Address:
NHS Number:

Responsible consultant / GP
Completing HCP (initials)
Date

Cultural, spiritual and religious support for patient and those important to them:

Consider the individual needs of the patient and those important to them. The Diversity Appendix offers practical advice. Discuss any particular priorities which may affect individual patient care. Document actions to be taken:

Individual plan of care

Update existing nursing care plans and risk assessments

Refer to Symptom Assessment Chart

Focus on measures to increase patient comfort. Stop interventions no longer providing symptomatic benefit.

Document decisions on the following:

- Monitoring of vital signs (e.g. NHS Early Warning Scores in hospital setting)
- Regular blood tests
- Monitoring blood sugar levels*
- Other:
- Investigations or appointments
- Management of Implantable Cardiac Device*
- Stopping VTE prophylaxis

Update existing nursing care plans and risk assessments in line with the above decisions.

In particular, address the following important aspects of care in the last days of life:

- Mouth care
- Skin
- Bladder/bowel
- Communication
- Environment - Privacy/Single room
- Symptom assessment
- Anticipatory medication
- Blood sugar level management*
- Hydration
- Nutrition

Symptom Control

- Rationalise current regular medication.
- Assess the patient for symptoms likely to occur in the last days of life (including pain, breathlessness, nausea and vomiting, anxiety, delirium, agitation, and noisy respiratory secretions).
- Document findings on the Symptom Assessment Chart.
- Prescribe anticipatory medication with individualised indications for use, dosage and route of administration.
- Refer to the Care Decisions Symptom Control Guidance, if needed.

*Refer to local/national guidance such as:

- Care Decisions Diabetes Management Supplement or EOLC Diabetes UK Clinical Care Recommendations (2021)
- All Wales Operational Document for Deactivation of ICD (guidance) (2019)

Ongoing review

Update existing nursing care plans and risk assessments

Continue to monitor **at least daily** for signs and symptoms, for example pain, breathlessness, nausea and vomiting, anxiety, delirium, agitation, and noisy respiratory secretions. Liaise with senior clinician if any concerns.

- Carry out regular symptom review, and discuss with senior colleagues if needed.
- Maintain frequent two-way communication with the patient (if they are able) and those important to them, taking into account that patient priorities may change over time.
- Discuss patient progress (and any changes) with the multi-disciplinary team.
- Consult your local Specialist Palliative Care Team for further advice if required.

Name:
 Date of Birth:
 Address:
 NHS Number:

Responsible consultant / GP
 Completing HCP (initials)
 Date

Understanding and priorities of those important to the patient:

With the patient’s consent, those important to the patient should be given opportunities to discuss and help plan the patient’s care. Offer information (including written material) about the role they can play to be involved and support care at this time.

Do those important to the patient understand the patient is dying? Yes No OR
 Patient has no important people/does not want anyone informed

Name of key individual to be involved / kept informed:

Relationship to patient:

Document discussion held with those important to the patient. Consider the following:
 What support do they have? What are their needs and concerns at this time?
 Are they aware how to access facilities, practical help or additional support, at home, in hospital or other setting?
 Are they aware of bereavement support available, if needed?
 If at home, do they know what to do when the person dies? **Document agreed plan:**

Verification of expected death: Refer to local policy for further guidance if needed

Can verification of death be carried out by a suitably trained healthcare professional (other than a GP or hospital doctor) according to the management of an ‘expected death’? Yes No

Medical Examiner / Coroner:

Will the death meet the statutory regulations to refer to the coroner? Yes No

Document reason and discussions with team and those important to the patient:

If referring to coroner, have you let next of kin know? Yes No N/A

Does next of kin know what will happen after death (including scrutiny from Medical Examiner)? Yes No

NB. For cultural/religious reasons, urgent death certificates and particular care of body may be needed by some families.)

IMPORTANT:

- If the clinical situation improves and the patient is **no longer deemed to be in the last days of life**, then the clinical team should discuss an alternative medical management plan. Care Decisions guidance should **no longer be used**. This should be indicated by drawing a line through each page, signed and dated.
- Please complete and return a Case Review sheet for each patient after death.

Identify responsible healthcare professionals: Ensure responsible clinician identified in box above

Healthcare professional (HCP) completing the document:

Print Name: Role: Date:
 Signature:

Discussed with senior clinical decision maker and plan agreed:

Print Name: Role: Date consulted:

Name:
Date of Birth:
Address:
NHS Number:



Care Decisions for the Last Days of Life Patient Symptom Assessment Chart/ Symptom Early Warning Score (SEWS)

General guidance / Prompts for all care settings:

- **Action:** Consider non-pharmacological measures to relieve symptoms as appropriate e.g. reassurance, repositioning, checking for bowel/bladder issues, offer oral care for dry mouth etc.
- **Action:** Consult the Care Decisions Symptom Control Guidance for information on managing symptoms or anticipatory medication prescribing.
- **Action:** Assess and record symptoms as per usual practice in your care setting. If symptoms worsen, increase the frequency of monitoring and update colleagues.
- **Action:** If symptoms persist, or patient scores at level 3 or 4 on 2 or more consecutive occasions, a review is required. Review symptoms and medication with a senior colleague and/or your local prescriber. If further support is needed contact your local SPCT. Contact numbers for SPCT OOH advice line are shown in the CDG Symptom Control Guidance.
- **Action:** Continue to assess symptoms regularly. Review symptoms as per usual local practice or at least daily (as per NICE Guidance (NG31), 2015).

Symptom score	What does this score mean? Patient has:	Advised ACTIONS for this score
4 – Overwhelming	Severe symptom(s)	Give prescribed PRN medication immediately and wait with patient to assess response. (It may take 20-30 mins for PRNs to take effect.) If symptom not settling as expected within 30 mins, contact a senior colleague, explaining fully the situation.
3 - Severe	Constant, unrelieved symptom(s)	Give prescribed PRN medication, and review after 30 mins to see if PRN has had required effect. Consider giving further PRN medication. If symptom(s) not adequately controlled within expected period consult a senior colleague, request a medical review or seek further advice from SPCT.
2 - Moderate	Frequent episodes of symptom(s)	Consider ‘as required’ PRN medication relating to symptom(s). If symptom(s) not adequately controlled within expected period consult a senior colleague, request a medical review or seek further advice from SPCT.
1 - Mild	Occasional symptom(s)	Consider ‘as required’ PRN medication, reviewing symptom(s) as agreed with patient. Agree review time / required action with patient to ensure symptom(s) resolves / remains under adequate control.
0 - None	Nil symptom(s)	Ongoing reference to patient’s care plan.

NB. This guidance does not replace the need for you to use your clinical judgement.



COMMUNITY MEDICATION ADMINISTRATION RECORD

DRUG ALLERGIES & SENSITIVITIES	PLEASE CIRCLE AS APPROPRIATE: NONE KNOWN YES	
	SIGNED..... DATE.....	
NAME.....		
Drug / Allergen:	Description of Reaction:	
This section must usually be completed prior to administration of any medicine. Refer to local policies for further guidance.		

HEALTH RECORD/NHS No: _____

SURNAME: _____

FIRST NAME: _____

ADDRESS: _____

DATE OF BIRTH: _____

CONSULTANT/GP: _____

DISTRICT NURSE TEAM: _____

DETAILS OF SUPPLEMENTARY CHARTS	
TICK APPROPRIATE BOX	
SYRINGE PUMP <input type="checkbox"/>	OTHER (Please specify) <input type="checkbox"/>

If starting a syringe pump, use the 'All Wales Continuous Subcutaneous Infusion Medication Administration Record'.

REGULAR MEDICATION THAT IS STILL REQUIRED

ENTER DOSE AGAINST TIME REQUIRED. USE ONE ROUTE ONLY FOR EACH ENTRY				REGULAR MEDICINE												MONTH												YEAR													
				DATE																																					
DATE →				MEDICINE (Approved Name)												SPECIAL INSTRUCTIONS												PRESCRIBER'S SIGNATURE													
ROUTE →																																									
SPECIFY TIME IF REQUIRED		DOSE		SIGN DOSE CHANGE																																					
		↓		↓																																					
Morning																																									
Midday																																									
Evening																																									
Bedtime																																									
DATE →				MEDICINE (Approved Name)												SPECIAL INSTRUCTIONS												PRESCRIBER'S SIGNATURE													
ROUTE →																																									
SPECIFY TIME IF REQUIRED		DOSE		SIGN DOSE CHANGE																																					
		↓		↓																																					
Morning																																									
Midday																																									
Evening																																									
Bedtime																																									

DATE	Oxygen (if required)	SPECIAL INSTRUCTIONS (Refer to local guidelines). Flow rate and delivery device: Target oxygen saturation (if appropriate): Or Indicate that oxygen use is for comfort measures only	PRESCRIBER'S SIGNATURE
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QUICK REFERENCE GUIDE: COMMONLY USED AS-REQUIRED MEDICINES AND DOSES:

INDICATION	MEDICINE	USUAL STRENGTH	DOSE	FREQUENCY	ROUTE
Pain / breathlessness (if opioid-naïve)	Morphine	10mg/mL	2.5mg	2 hourly	SC
Agitation (anxiety)	Midazolam	10mg/2mL	2.5 or 5mg	2 hourly	SC
Agitation (delirium)	Haloperidol	5mg/mL	2.5mg	4 hourly	SC
	Levomepromazine	25mg/mL	6.25 or 12.5mg	up to 6 hourly	SC
Nausea / Vomiting	Cyclizine	50mg/mL	50mg	4 hourly (max 150mg/24hours)	SC
	Haloperidol	5mg/mL	1mg-1.5mg	4 hourly	SC
	Levomepromazine	25mg/mL	6.25mg	4 hourly (max 25mg/24hours)	SC
Noisy resp. secretions	Hyoscine hydrobromide	400mcg/mL	400 micrograms	4 hourly (max 2.4mg/24hours)	SC
	Glycopyrronium	200mcg /mL	200 micrograms	4 hourly (max 1.2mg/24 hours)	SC

Remember to supply water for injection along with anticipatory medication

COMMUNITY MEDICATION ADMINISTRATION RECORD

PATIENT'S NAME.....

HEALTH RECORD No.

Important note 1: For some symptoms the same medicine is used in a different dose. If this is the case, please make a separate entry.

*** Important note 2:** It is good practice to indicate a maximum dose in 24 hours. This aids timely clinical review if frequent as-required doses are needed. The maximum dose indicated should include both as-required and regular medication (e.g. medication via CSCl).

AS REQUIRED MEDICINES				DATE	TIME GIVEN	DOSE/ROUTE	GIVEN BY	DATE	TIME GIVEN	DOSE/ROUTE	GIVEN BY	DATE	TIME GIVEN	DOSE/ROUTE	GIVEN BY
INDICATION Pain / Breathlessness		MEDICINE (Approved name)													
DOSE	ROUTE	FREQUENCY	MAX DOSE IN 24 HRS *												
PRESCRIBER'S SIGNATURE			DATE												
INDICATION Agitation (Anxiety)		MEDICINE (Approved name)													
DOSE	ROUTE	FREQUENCY	MAX DOSE IN 24 HRS *												
PRESCRIBER'S SIGNATURE			DATE												
INDICATION Agitation (Delirium)		MEDICINE (Approved name)													
DOSE	ROUTE	FREQUENCY	MAX DOSE IN 24 HRS *												
PRESCRIBER'S SIGNATURE			DATE												
INDICATION Nausea / Vomiting		MEDICINE (Approved name)													
DOSE	ROUTE	FREQUENCY	MAX DOSE IN 24 HRS *												
PRESCRIBER'S SIGNATURE			DATE												
INDICATION Noisy resp. secretions		MEDICINE (Approved name)													
DOSE	ROUTE	FREQUENCY	MAX DOSE IN 24 HRS *												
PRESCRIBER'S SIGNATURE			DATE												
INDICATION Dry mouth		MEDICINE (Approved name)													
DOSE	ROUTE	FREQUENCY	MAX DOSE IN 24 HRS *												
PRESCRIBER'S SIGNATURE			DATE												
INDICATION		MEDICINE (Approved name)													
DOSE	ROUTE	FREQUENCY	MAX DOSE IN 24 HRS *												
PRESCRIBER'S SIGNATURE			DATE												

Please complete and return this sheet for all deceased patients.

This sheet is used to evidence the quality of care provided at the end of life in Wales (with or without the use of Care Decisions guidance).

*Please complete/tick all answers that are relevant. (If no evidence exists, 'No' should be ticked.)

Last Days of Life Care in Wales: Individual Case Review Sheet

Health Board area: Name of org/establishment/ team reporting: Location/base/area team covers (to attribute data): Patient's Care Setting: <input type="checkbox"/> Own home <input type="checkbox"/> Residential Home <input type="checkbox"/> Nursing Home <input type="checkbox"/> Community Hospital <input type="checkbox"/> Acute hospital <input type="checkbox"/> SPC IPU / Hospice <input type="checkbox"/> other.....	About the deceased: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other Age: Primary diagnosis: <input type="checkbox"/> Cancer <input type="checkbox"/> Non-cancer <input type="checkbox"/> Unknown
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Priority 1: The possibility that a person may die within the coming days and hours is recognised and communicated clearly, decisions about care are made in accordance with the person's needs and wishes, and these are reviewed/revised regularly.

Recognising the dying phase:

- Was the patient seen by a senior clinician in their last days? Yes No
- Was it documented that the team agreed the patient is likely to be in the last days or hours of life? Yes No

Recognising the patient's needs and wishes in their last days of life:

- Was it documented that the patient was asked about or had already indicated their needs and wishes? Yes No
- Was the patient where they preferred to be cared for in the last days of life? Yes No
- If not, why not?
- Was it documented that arrangements/plans were reviewed and revised as needs changed? Yes No

Priority 2: Sensitive communication takes place between staff and the person who is dying and those important to them.

- Was there evidence of sensitive discussions with the patient about their last days of life? Yes No
Was the patient unable to discuss (e.g. Dementia, confused, lacked capacity, no communication) Yes
Did the patient clearly indicate that they did not want to discuss the issue Yes
- Was there evidence of discussion with those important to the patient regarding last days of life? Yes No
No important people were identified by patient or patient did not want them involved Yes

Priority 3: The dying person, and those identified as important to them, are involved in decisions about treatment and care.

- Was there evidence that opportunities were given to the patient and those important to them to be involved in discussions about treatment and care? Yes No n/a

Priority 4: The people important to the dying person are listened to and their needs are respected.

- Was there evidence that those important to the patient were listened to and their needs respected? Yes No
- Were those important to the patient made aware of the practical support and information available to them (before and after death) e.g. hospital facilities/increased nursing care at home/booklet/sign posting Yes No n/a

Priority 5: Care is tailored to the individual and delivered with compassion – with an individual care plan in place.

Was there documented evidence of:

- Holistic individualised care planning being undertaken (*this may include: physical, psychological, spiritual, cultural, religious needs assessment and action planning*) Yes No
- Appropriate anticipatory medication, tailored to the needs of the patient, being available Yes No
- At least daily monitoring of signs and symptoms, including need for parenteral fluids Yes No

Other: Documentation: Were any of the following documents used?

- (i) Main Care Decisions Guidance (4 pages) (Document A) Yes No
- (ii) Symptom assessment chart (Document B) Yes No
- (iii) Symptom control guidance (flow diagrams) (Document E) Yes No

Any further comment on care or if any aspect not fulfilled, why?	Return completed sheets to your local audit dept or: <ul style="list-style-type: none"> Email: CareDecisions@wales.nhs.uk Post: Care Decisions Manager, Dept of Palliative Care, Bodfan, Eryri Hospital, Caernarfon, Gwynedd. LL55 2YE. Fax: FAO Care Decisions Team 03000 851669
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All Wales Guidance: Care Decisions for the Last Days of Life

Symptom Control Guidance



Introduction

This guideline is an aid to clinical decision-making in managing common symptoms which can occur in people in the last days of life.

- **Regular assessment of symptoms remains important.**
 - Assess the patient for symptoms likely to occur in the last days of life (including pain, breathlessness, nausea and vomiting, anxiety, delirium, agitation, and noisy respiratory secretions).
 - **Consider reversible causes of symptoms** e.g. pain or agitation caused by urinary retention or constipation.
- **Management requires an individualised approach to the patient.**
 - An individualised approach may suggest a different medication/dose/strategy being indicated to those listed as 1st line in the guidance.
 - There should also be **consideration of non-pharmacological strategies** in addition to medication to manage symptoms e.g. positioning, environment, reassurance.
- **Medication considerations:**
 - **Prescribe anticipatory (including injectable) medication** with individualised indications for use, dosage and route of administration. Such injectable subcutaneous (SC) medication should be available for use in anticipation of the common symptoms in the last days of life even if these symptoms are not yet present.
 - **Continuous subcutaneous infusion (CSCI)** using a syringe driver/pump is indicated if a patient requires regular symptom control medication but can no longer take this by mouth or if there are concerns about absorption from the oral route.
 - It is good practice to **indicate a maximum dose in 24 hours**. This aids timely clinical review if frequent as-required doses are needed. The maximum dose indicated should include both as-required and regular medication (e.g. medication via CSCI).
 - Where CSCI is required the diluent should be water for injection. Contact pharmacy for advice if drug compatibility is a problem.

Contact your local specialist palliative care team (SPCT) for more advice.

With the OOH service outlined below, support is available 24/7

Out of Hours Specialist Palliative Medicine Telephone Advice Line:

- **North Wales:** 01745 585221
- **South East Wales** (via UHW switchboard): 02920 747747
- **South East Powys** (Royal Glamorgan / Royal Gwent Hospitals): 01443 443443 / 01633 234234
- **South West Wales & South West Powys** (Morrison Hospital): 01792 703412 / 01792 702222
- **Mid Powys** (St Michael's Hospice): 01432 852080
- **North Powys** (Severn Hospice): 01743 236565

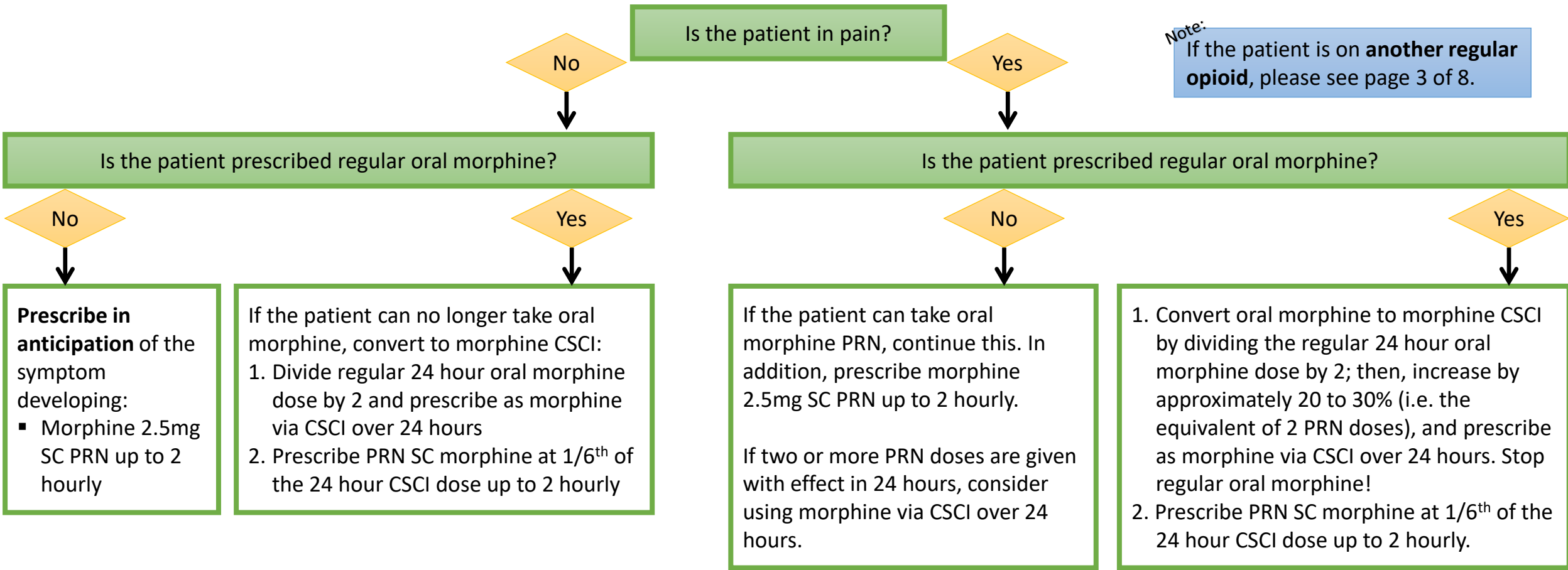
For more information see:

- Current version of the BNF
- Current version of the PCF (Palliative Care Formulary)
- Palliative Care (Adult) Network Guidelines - PANG. Max Watson, Peter Armstrong, Craig Gannon, Nigel Sykes, Ian Back. 2017 [Palliative Care Guidelines Plus \(pallcare.info\)](http://pallcare.info)

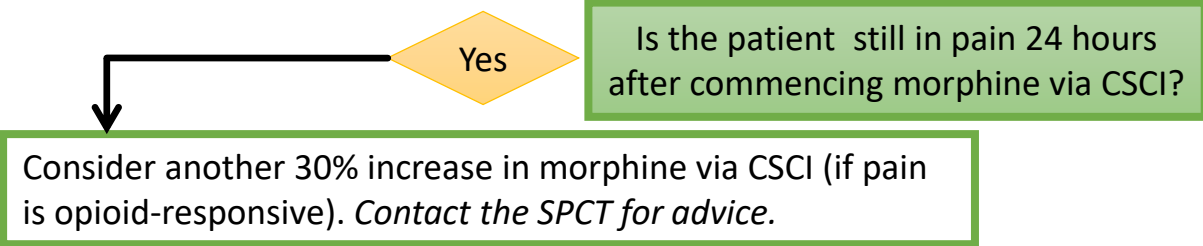
Acknowledgements: This document has been developed in accordance with NICE guidance 'Care of dying adults in the last days of life' (NG31, 2015, [Overview | Care of dying adults in the last days of life | Guidance | NICE](#), NG142, 2019, [Overview | End of life care for adults: service delivery | Guidance | NICE](#)) and e-Learning for Health EOLC module ([HEE elfh Hub \(e-lfh.org.uk\)](http://HEE_elfh_Hub(e-lfh.org.uk))). It describes pragmatic practice.

The management of pain with morphine in the last days of life

Note:
If the patient is on **another regular opioid**, please see page 3 of 8.



Note:
Caution required in **renal and/or hepatic impairment** – alternative dosing or medication choice may be required – see page 8 of 8.



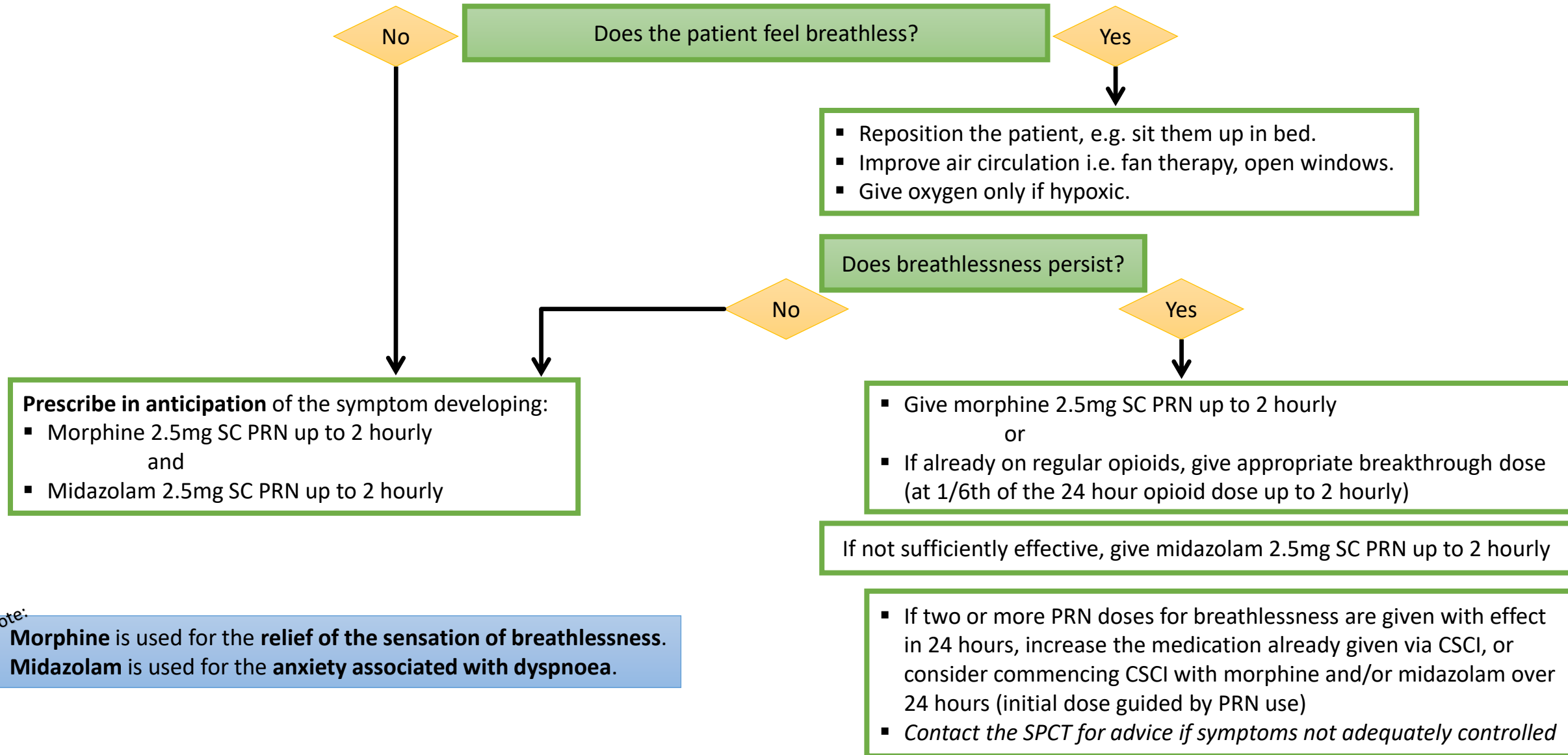
Other pain management considerations in the last days of life – V 12 update

Diamorphine	Oxycodone	Fentanyl/Buprenorphine patch(es)	Renal impairment / renal failure
<ul style="list-style-type: none"> ▪ Diamorphine can be useful where large doses of opioid is needed as smaller volume is required. ▪ To convert oral morphine to SC diamorphine divide by 3: E.g. 30mg oral morphine = 10mg SC diamorphine ▪ All the other prescribing principles remain the same as morphine. 	<ul style="list-style-type: none"> ▪ Oxycodone may be useful where morphine not tolerated or contraindicated. ▪ Oxycodone is often favoured over morphine in mild to moderate renal impairment but caution still required. ▪ Oxycodone is generally contraindicated in moderate to severe hepatic failure. <p>For converting oral oxycodone to SC oxycodone two different conversions are commonly used. Either:</p> <ul style="list-style-type: none"> ▪ Reduce dose by 1/3: E.g. 30mg oral oxycodone = 20mg SC oxycodone OR ▪ Reduce dose by 1/2: E.g. 30mg oral oxycodone = 15mg SC oxycodone <p>Contact the SPCT for advice if needed.</p>	<ul style="list-style-type: none"> ▪ Leave the patch in situ when commencing a CSCI and continue to change at prescribed frequency. ▪ PRN dose should be roughly 1/6th of the 24 hour opioid dose including both equivalent patch and CSCI doses. ▪ See BNF “prescribing in palliative care” section for conversion details or <i>contact the SPCT for advice</i> if needed. 	<p><i>Seek advice from SPCT or renal specialists for patients with end stage renal failure (ESRF).</i></p> <ul style="list-style-type: none"> ▪ <i>Drug elimination will be significantly slower.</i> ▪ <i>PRNs alone may be sufficient.</i> <p>Pain:</p> <ul style="list-style-type: none"> ▪ Oxycodone is an alternative to morphine in mild to moderate renal impairment (caution is still needed). ▪ Start with low doses: 1 or 2mg SC 4 hourly PRN and titrate slowly, monitoring the patient for toxicity. Seek SPCT advice if a CSCI is required for the safest analgesic.
		Alfentanil	
		<ul style="list-style-type: none"> ▪ Alfentanil can be used in moderate to severe renal impairment, <i>but only under the direction of specialist palliative care team.</i> ▪ To convert oral morphine to SC alfentanil divide by 30: E.g. 30mg oral morphine = 1mg alfentanil 	<p><i>Note:</i></p> <p>Where alfentanil is used via CSCI the PRN dose will likely be morphine or oxycodone as alfentanil is too short-acting to be suitable for PRN use.</p>

Note:
PRN doses will generally be approximately 1/6th of the total equivalent regular daily opioid dose.

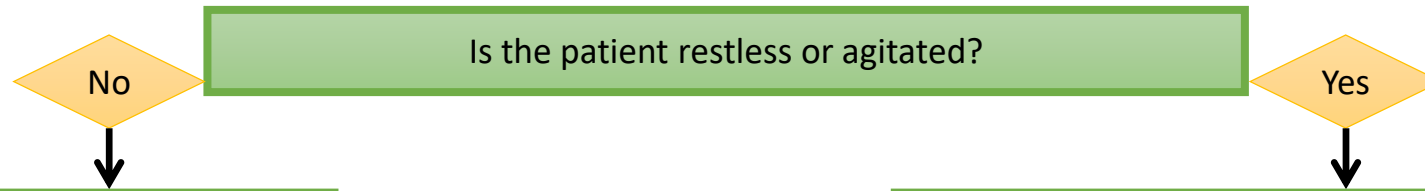
Note:
Where **alfentanil** is used via CSCI the PRN dose will likely be morphine or oxycodone as alfentanil is too short-acting to be suitable for PRN use.

The management of breathlessness in the last days of life



Note:
Morphine is used for the **relief of the sensation of breathlessness.**
Midazolam is used for the **anxiety associated with dyspnoea.**

The management of agitation and restlessness in the last days of life



Prescribe in anticipation of the symptom developing:

- For agitation (anxiety): Midazolam 2.5 or 5mg SC PRN up to 2 hourly
- For agitation (delirium): Haloperidol 2.5mg SC PRN up to 4 hourly

Consider and resolve where possible any underlying causes such as:

- Uncontrolled pain
- Full bladder
- Full rectum
- Breathlessness
- Anxiety and fear

If the patient’s distress cannot be otherwise relieved:

1. If **delirium** and psychotic features are predominant (e.g. hallucinations, confusion, restlessness),
 - Give haloperidol 2.5mg SC PRN up to 4 hourly.
 - If two or more PRN doses of medication are given with effect in 24 hours, consider using the medication via CSCI over 24 hours.
 - Levomepromazine 6.25 or 12.5mg SC PRN up to 6 hourly is an alternative to haloperidol.

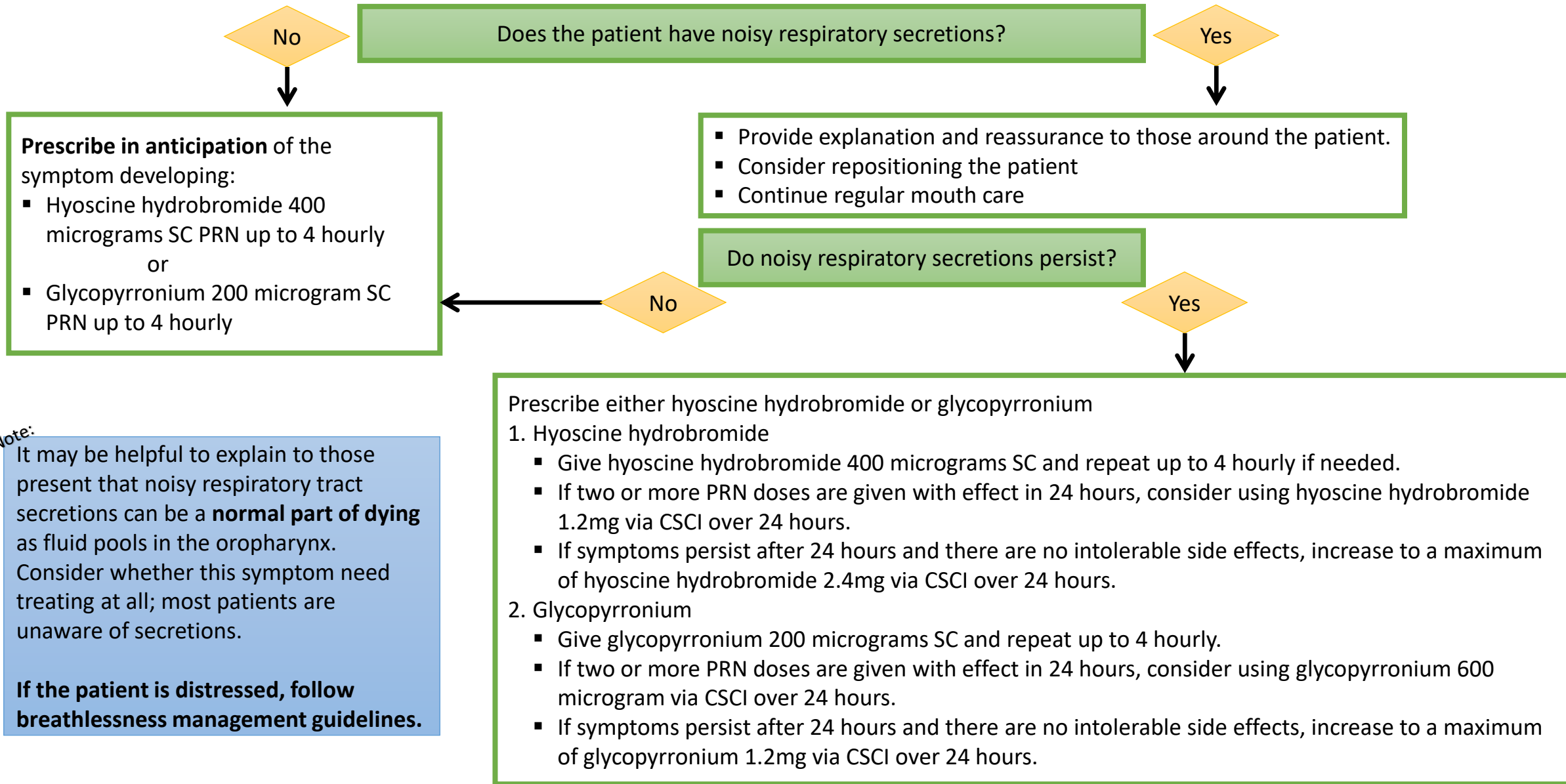
If symptoms persist, contact the SPCT for advice. In certain circumstances, the SPCT may advise larger doses than the ones stated above.
2. Where **anguish and anxiety** are prominent,
 - Give midazolam 2.5 or 5mg SC PRN up to 2 hourly.
 - If two or more PRN doses of midazolam are given with effect in 24 hours, consider using midazolam 10mg via CSCI over 24 hours.
 - The CSCI dose of midazolam may need to be increased gradually up to 30mg over 24 hours.

If symptoms persist, or if frequent PRN doses used, contact the SPCT for advice. In certain circumstances, the SPCT may advise larger or more frequent doses than the ones stated above.

Note:

Terminal agitation is often a feature of hyperactive delirium and therefore antipsychotics are commonly used first line, either alone or in combination with a benzodiazepine.

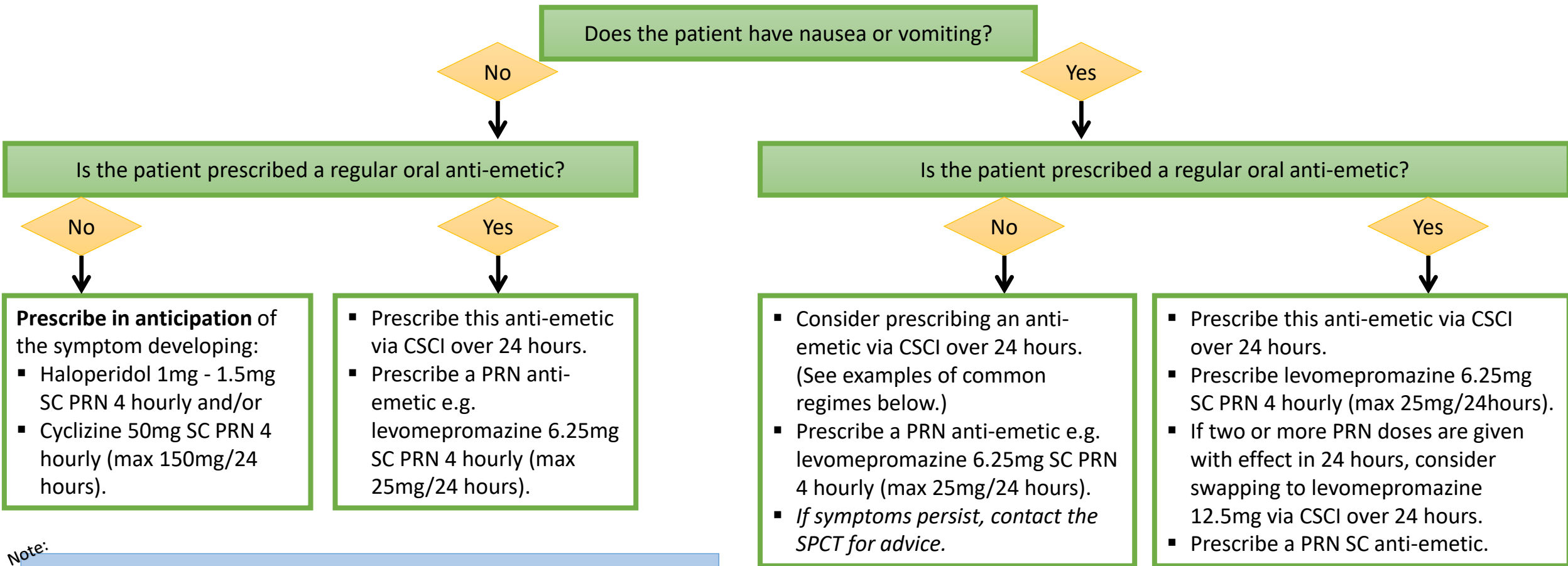
The management of noisy respiratory secretions ('rattle') in the last days of life



Note:
It may be helpful to explain to those present that noisy respiratory tract secretions can be a **normal part of dying** as fluid pools in the oropharynx. Consider whether this symptom need treating at all; most patients are unaware of secretions.

If the patient is distressed, follow breathlessness management guidelines.

The management of nausea and vomiting in the last days of life



Note:
 Considering the **likely cause** of nausea/vomiting to help decide the most appropriate 1st line anti-emetic:

- Toxic/ biochemical causes (e.g. renal failure, opioids, hypercalcaemia) – **haloperidol**
- Vestibular causes/ raised intracranial pressure – **cyclizine**
- Gastric stasis/ functional bowel obstruction – **metoclopramide**
- In **Parkinson’s disease**, consider Ondansetron first line (see page 8 of 8)

Levomepromazine is a broad spectrum anti-emetic and is often used second or third line.

Note:
 Examples of common anti-emetic regimens for nausea/vomiting in the last days of life:

- Haloperidol via CSCI over 24 hours, Cyclizine or Levomepromazine PRN
- Cyclizine (+/- Haloperidol) via CSCI over 24 hours, Levomepromazine PRN
- Metoclopramide via CSCI over 24 hours, Levomepromazine PRN
- Levomepromazine via CSCI over 24 hours, Levomepromazine and/or Ondansetron PRN

Do not use Cyclizine and Metoclopramide together, as they counter-act each other.

Special considerations in the last days of life

Renal impairment / renal failure

Seek advice from SPCT or renal specialists for patients with end stage renal failure (ESRF). Drug elimination will be significantly slower. PRNs alone may be sufficient.

Pain: see page 3 for prescribing advice.

Other symptoms:

- Most symptom control medications can be used in renal impairment with caution.
- Glycopyrronium is preferred to hyoscine hydrobromide in ESRF.
- Consider starting with lower doses and/or longer dosing intervals, especially midazolam, haloperidol and levomepromazine.
- Refer to BNF for further information.

Seizures

- If there is a risk of seizures, prescribe buccal midazolam 10mg PRN.
- If on regular oral anti-epileptic medication(s) and unable to take these, *seek SPCT advice* regarding the best medicine to use via CSCI over 24 hours.

Heart failure

- Heart failure medications may offer significant symptom relief: So, where possible, do not abruptly stop these medications just because the patient is entering their last days of life.
- Opioids and midazolam can be helpful for breathlessness. Dose adjustment is needed if the patient has concurrent renal impairment.
- Avoid cyclizine.
- Diuretics can sometimes be given subcutaneously – *seek advice from the heart failure team or SPCT.*

Parkinson's disease

- Avoid anti-dopaminergic medications e.g. haloperidol, metoclopramide and levomepromazine.
- *Seek advice from Pharmacy, Care of the Elderly, Parkinson's CNS, or SPCT colleagues.*
- If unable to take oral Parkinson's medications consider using a rotigotine transdermal patch starting at 2mg/24 hours. *Please note that online dose conversion tables may be unreliable.*

Liver failure

Pain:

- Morphine is first-line strong opioid of choice
- Use lowest effective dose (reduced dosage and/or extended dose interval), titrate slowly and monitor for toxicity.
- e.g. morphine 2.5 mg SC PRN 2 hourly.
- Seek SPCT advice if concurrent renal impairment.

Other symptoms:

- Use lower doses of midazolam, haloperidol and levomepromazine.
- Use Glycopyrronium for secretions (avoid Hyoscine Hydrobromide).

Diabetes management

- For advice on diabetes management in the last days of life, see Supplementary document.
- *Seek advice from Diabetes team or SPCT if needed.*



Swansea Bay University Health Board

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