Care in the Last Days of Life

Introduction

This guideline is an aid to clinical decision making and good practice in care for patients who are deteriorating and expected to die imminently. While this guideline focuses on physical symptoms, psychosocial and spiritual issues also need to be addressed to give holistic care.

Assessment

- Consider any potentially reversible causes for the patient’s deterioration and agree realistic levels of intervention with the patient and family. These may include:
  - dehydration
  - infection
  - opioid toxicity
  - steroid withdrawal
  - acute kidney injury
  - delirium
  - hypercalcaemia
  - hypo or hyperglycaemia.

If potentially reversible causes are identified, commence treatment and plan review, if appropriate for the individual patient and care setting.

If no reversible causes are identified and the patient is expected to die imminently:

- discuss with the patient and family that they are deteriorating and expected to die imminently, although it is often not possible to give a precise prognosis
- establish goals of care and preferred place of care with the patient or a welfare attorney, and the family
- take account of any advance/anticipatory care planning or documented patient wishes
- agree an individual care plan with the patient if possible or any welfare attorney, discuss with the family, and document in the patient record:
  - this includes a decision about cardio pulmonary resuscitation
  - explain to the patient and their family that all support, care and treatment that are of benefit will continue to be given and reviewed
- prompt and careful planning, if appropriate and in line with the individual’s wishes, is needed for a safe discharge home or to an appropriate place of care
- if patient or family needs are complex, consider contacting the specialist palliative care team for advice.
Management

Care planning and regular review

Care should be actively aimed at achieving a good and dignified death. Regular planned review and documentation of the care plan will make sure the best care is given as the patient’s condition deteriorates, stabilises or improves.

- Food and drinks: support the patient to take these as long as they are able and want to.
- Essential comfort care: usually includes an alternating pressure mattress to minimise avoidable skin breakdown, repositioning for comfort, eye, mouth, bladder and bowel care.
- Medication:
  - stop any treatments not consistent with the agreed goals of care
  - continue medications consistent with goals of care
  - consider the need for any immediate additional medication
  - make sure anticipatory medications for common symptoms are available and prescribed for as required use
  - ensure most appropriate route for each medication
  - consider the need for a subcutaneous (SC) infusion of medication via a syringe pump.
- Investigations or clinical interventions are unlikely to be of benefit at this stage. Make a clear record of any interventions that are not appropriate.
- Assisted hydration or nutrition: consider the benefits and risks and review plan regularly.
  - Over-hydration can contribute to distressing respiratory secretions. However, where indicated, a slow SC fluid infusion may be considered on an individual basis (refer to Subcutaneous Fluids guideline).
- Consider emotional, spiritual, religious, cultural, legal and family needs, including those of children and people with cognitive impairment or learning disability.
- Bereavement: identify those at increased risk of complicated grief and seek additional support.

Communication

- Discuss the care plan with the patient, if possible, and the family, and explain what changes to expect in the patient’s condition. Sensitively explore wishes about organ and tissue donation where appropriate.
- For patients not being cared for at home, ensure family members are aware of the care plan and that details of how and when to contact the family if the patient deteriorates or dies are recorded. For patients at home, ensure family and carers know who to contact if the patient deteriorates or dies.
• Ensure that all health and social care professionals involved or who may become involved, for example out-of-hours community services or hospital at night team, are aware that the person is thought to be in the last days of life and have access to an up-to-date care plan.

Symptom control in the last days of life

Anticipatory prescribing

• All patients should have as required medication for symptom control available (refer to Anticipatory Prescribing guideline).

• Opioid analgesic for pain or breathlessness SC, hourly. If 3 or more doses have been given within 4 hours with little or no benefit seek urgent advice or review. If more than 6 doses are required in 24 hours seek advice or review.

• Dose depends on the patient, clinical problem and previous opioid use.
  - 1/6th to 1/10th of 24 hour dose of any regular opioid and converted to SC dose.
  - If no previous opioid- starting dose is morphine SC 2mg.

• Anxiolytic sedative: midazolam SC 2mg to 5mg, hourly. If 3 or more doses have been given within 4 hours with little or no benefit seek urgent advice or review. If more than 6 doses are required in 24 hours seek advice or review.

• Antisecretory medication: †hyoscine butylbromide SC 20mg, hourly. Maximum 6 doses in 24 hours.

• Anti-emetic: QT †levomepromazine SC 2.5mg to 5mg, 12 hourly. May need to be given more frequently initially, for example hourly, to control symptoms. If 3 or more doses have been given within 4 hours with little or no benefit seek urgent advice or review. If more than 6 doses are required in 24 hours seek advice or review.

• Levomepromazine can be used in terminal agitation or agitated delirium under specialist advice at a different dose (refer to anxiety, distress, delirium section below)

Pain

• Paracetamol (PR dose) or diclofenac (SC dose). For pain or high temperature.

• The benefits of non-steroidal anti-inflammatory drugs (NSAIDs) may outweigh the risks in a dying patient and can help bone, joint, pressure sore and inflammatory pain.

• If prescribed regular oral opioids and the oral route is no longer reliable, convert the total 24 hour oral morphine or oxycodone dose to a 24 hour SC infusion, for example:

<table>
<thead>
<tr>
<th>oral morphine 30mg</th>
<th>≈ SC morphine 15mg</th>
<th>≈ SC diamorphine 10mg</th>
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<tbody>
<tr>
<td>oral oxycodone 15mg</td>
<td>≈ SC oxycodone 7mg to 8 mg</td>
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† Indicates this use is off licence
QT Indicates this medication is associated with QT prolongation
- For opioid dose conversions, refer to Choosing and Changing Opioids guideline or seek advice.
- Fentanyl patches should be continued in dying patients (refer to Fentanyl Patches information sheet).
- For a patient with stage 4–5 chronic kidney disease, refer to Renal Disease in Last Days of Life guideline.
- Breakthrough analgesia, should be prescribed hourly, as required:
  - 1/6th to 1/10th of 24 hour dose of any regular opioid orally and SC
  - If not on any regular opioid, use morphine SC 2mg.

### Anxiety, Distress or Delirium

<table>
<thead>
<tr>
<th></th>
<th>Details</th>
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<tbody>
<tr>
<td><strong>Intermittent</strong> anxiety or distress</td>
<td>Midazolam SC 2mg to 5mg, hourly, as required. If 3 or more doses have been given within 4 hours with little or no benefit seek urgent advice or review. If more than 6 doses are required in 24 hours seek advice or review.</td>
</tr>
<tr>
<td><strong>Persistent</strong> anxiety/distress or delirium</td>
<td><strong>First step:</strong> Midazolam SC 10mg to 20mg over 24 hours in a syringe pump + midazolam SC 5mg hourly, as required. <strong>Second step:</strong> Titrate Midazolam with advice, starting at 10mg over 24 hours in a syringe pump. Doses can be gradually titrated up to 60mg over 24 hours under specialist advice. Levomepromazine may need to be used in addition to midazolam under specialist advice. Use lower doses if not used previously and in frail elderly, for example, 2.5mg to 5mg SC as required 2 hourly. Higher doses may be needed for persistent distress or delirium for example, 10mg to 25mg SC as required 2 hourly. May need to be given more frequently initially, for example, hourly to control symptoms. Stop any QT haloperidol.</td>
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### Nausea and vomiting

(Refer to Nausea and Vomiting guideline)

- If already controlled with an oral anti-emetic, use the same drug as an SC infusion.
- Treat new nausea and vomiting with a long acting anti-emetic given by SC injection or give a suitable anti-emetic as a 24 hour SC infusion in a syringe pump.

Long acting anti-emetics:
haloperidol SC 1mg 12 hourly, or 2mg once daily.
levomepromazine SC 2.5mg to 5mg, 12 hourly. May need to be given more frequently initially, for example hourly, to control symptoms.

For doses of anti-emetics for use in a SC infusion, refer to Table 1 in the Syringe Pumps guideline.
Persistent vomiting: a nasogastric tube, if tolerated, may be better than medication.

**Breathlessness**

(Refer to Breathlessness guideline)
- Oxygen can improve breathlessness, but only if the patient is hypoxic. If oxygen is needed for symptom control, nasal prongs may be better tolerated than a mask.
- A fan (either on a table or handheld) should be tried, and a more upright position can help.

<table>
<thead>
<tr>
<th>Intermittent breathlessness or respiratory distress</th>
<th>Opioid:</th>
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<tbody>
<tr>
<td>If already on regular opioid - use the same hourly breakthrough dose for pain or breathlessness. Review dose as appropriate and ensure ‘as required’ medication is prescribed.</td>
<td></td>
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<tr>
<td>If no previous opioid – starting dose is morphine SC 2mg. If 3 or more doses have been given within 4 hours with little or no benefit seek urgent advice or review. If more than 6 doses are required in 24 hours seek advice or review.</td>
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<tr>
<td>Anxiolytic sedative:</td>
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<td>Midazolam SC 2mg to 5mg up to hourly. If 3 or more doses have been given within 4 hours with little or no benefit seek urgent advice or review. If more than 6 doses are required in 24 hours seek advice or review.</td>
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| Persistent breathlessness or respiratory distress | Morphine SC 5mg to 10mg (if no previous opioid use) + midazolam SC 5mg to 20mg via syringe pump over 24 hours. |

**Respiratory tract secretions**

- Reduce risk by avoiding fluid overload and review any assisted hydration or nutrition (intravenous [IV] or SC fluids, feeding) if symptoms develop. Suction may also exacerbate secretions.
- Changing the patient’s position, for example head down or lateral position may help.
- Intermittent SC injections often work well or medication can be given as an SC infusion (be aware that conscious patients may be troubled by dry mouth on these medications, refer to Mouth Care guideline):
  - **first-line**: hyoscine butylbromide SC 20mg, hourly as required (up to 120mg over 24 hours)
  - **second-line**: glycopyrronium bromide SC 200micrograms, 6 to 8 hourly as required
  - **third-line**: hyoscine hydrobromide SC 400micrograms, 2 hourly as required.
Acute terminal events
(Refer to Emergencies in Palliative Care guidelines)

- Dying patients occasionally develop acute distress. This can be due to:
  - bleeding: haemorrhage from gastrointestinal or respiratory tract, or an external tumour
  - acute pain: bleeding into a solid tumour, fracture, or ruptured organ
  - acute respiratory distress: pulmonary embolism or retained secretions.

- Prescribe sedation in advance if the patient is at risk and warn the family. Agree an anticipatory care plan with the patient, if possible, and family, carers and key professionals.

- Give midazolam 5mg to 10mg intramuscular (IM), or IV, if available.

- If the patient is in pain or has respiratory distress, give morphine SC at the usual breakthrough as required dose. Repeat if necessary.

Practice points

- Opioid analgesics should not be used to sedate dying patients.

- If sudden increase in pain or agitation occurs exclude urinary retention or other reversible causes.

- SC infusions of medication provide maintenance treatment only. Additional doses of medication by SC injection will be needed if the patient’s symptoms are not controlled, or when starting an SC infusion in an unsettled patient.

- Midazolam SC infusions are usually titrated in 5mg to 10mg steps. Single SC doses usually last 1 to 2 hours. Useful as an anticonvulsant.

- Consider a nicotine replacement patch in heavy smokers with withdrawal symptoms.

Resources


Syringe Pumps (guidance on prescribing advice and drug compatibility tables)

Choosing and Changing Opioids

Subcutaneous Fluids

Mouth Care

Levomepromazine

Renal Disease in the Last Days of Life

End Stage Liver Disease

Patient and carer resources


