FAR WEST LHD – ANTICIPATORY PRESCRIBING RECOMMENDATIONS for LAST DAYS OF LIFE (LDoL) MEDICATIONS

in line with Clinical Excellence Commission LAST DAYS OF LIFE TOOLKIT

- All patients in the last days of life should have subcutaneous PRN medications prescribed pre-emptively to ensure there is no delay in treating the common symptoms that may be experienced by dying patients if they occur.
- This guide includes the recommended STARTING doses for FIRST LINE medications to be pre-emptively prescribed for all dying patients. Doses should be adjusted and titrated to meet the assessed needs of the individual patient.
- These recommendations should be used in conjunction with the notes overleaf, and the CEC Last Days of Life Guidance Notes, Symptom Management Flowcharts and Comfort Observation and Symptom Assessment (COSA) Chart.

Drug	Formulations	Indication(s)	STARTING PRN DOSE for PRN medication	STARTING DOSE for REGULAR medication	FWLHD COMMUNITY LDoL Medication Orders	FWLHD COMMUNITY LDoL Medication Pack	Guidance Notes
MORPHINE **OR** **FENTANYL** (in end stage kidney disease: eGFR <30)	**MORPHINE** 10mg/1mL 15mg/1mL 30mg/1mL 120mg/1.5mL **FENTANYL** 50mcg/1mL 100mcg/2mL 500mcg/10mL	**PAIN** **&** **1st line for BREATHLESSNESS**	**If not taking regular opioid (not on opioid for previous seven days)** **MORPHINE** 2.5mg subcut 1 (one) hourly PRN max PRN dose in 24 hrs = 15mg (equivalent to 6 PRN doses) **FENTANYL (if eGFR <30)** 25mcg subcut 1 (one) hourly PRN max PRN dose in 24 hrs = 150mcg (equivalent to 6 PRN doses)	See CEC LDoL Toolkit pain and/or breathlessness management flowcharts for guidance on commencing morphine in subcut syringe driver (plus PRN opioid)	**MORPHINE** **PRN if needed** 2.5 to 5mg subcut 1 hourly **Syringe driver if needed** 10 to 20mg in CSCI over 24hrs **FENTANYL** **PRN if needed** 25 to 50mcg subcut 1 hourly **Syringe driver if needed** 100 to 200mcg in CSCI over 24hrs	**MORPHINE** **10 amps of 10mg/1mL (Authority PBS)** (Phone authority required for >5 amps) **OR** **FENTANYL** **10 amps of 50mcg/1mL (non-PBS)** (Private Community or FWLHD Hospital Script)	• Morphine is recommended as first line subcut opioid for majority of patients in the last days of life • Fentanyl is preferred if patient has end stage kidney disease (eGFR <30) • Seek advice from local Specialist Palliative Care Team if conversion to alternative subcut opioid is required (see below for contact details)
			If on regular opioid (regular opioid use during previous seven days) See CEC LDoL Toolkit pain and/or breathlessness management flowchart AND opioid chart on reverse of pain flowchart for guidance on conversion of oral/transdermal opioid to equivalent morphine in subcut syringe driver				
METOCLOPRAMIDE	10mg/2mL	**1st line for NAUSEA/VOMITING**	10mg subcut 8 hourly PRN max PRN dose in 24 hrs = 30mg (equivalent to 3 PRN doses)	30mg subcut in 24 hr syringe driver (plus PRN haloperidol)	**PRN if needed** 10mg subcut 8 hourly **Syringe driver if needed** 30mg in CSCI over 24hrs	**20 amps of 10mg/2mL (Streamline PBS)** (Streamline authority required for >10 amps)	**Metoclopramide** • Max subcut PRN volume =10mg (2mLs) • Caution with abdominal colic • Do not use if bowel obstruction suspected **Haloperidol** • Preferred antiemetic in renal impairment **Metoclopramide & Haloperidol** • Do not use in Parkinson's Disease or Lewy Body Dementia • Watch for extrapyramidal side effects (repetitive and involuntary movements, abnormal restlessness and parkinsonism including tremor, rigidity and bradykinesia)
HALOPERIDOL	5mg/1mL	**2nd line for NAUSEA/VOMITING** **&** **1st line for RESTLESSNESS/AGITATION**	1mg subcut 4 hourly PRN max PRN dose in 24 hrs = 3mg (equivalent to 3 PRN doses)	2mg subcut in 24 hr syringe driver (plus PRN haloperidol)	**PRN if needed** 1mg subcut 4 hourly **Syringe driver if needed** 2 to 5mg in CSCI over 24hrs	**5 amps of 5mg/1mL (PBS)** (Authority required if >10 amps)	
MIDAZOLAM	5mg/1mL 15mg/3mL	**2nd line for RESTLESSNESS/AGITATION** **&** **2nd line for BREATHLESSNESS with ANXIETY**	2.5mg subcut 2 hourly PRN max PRN dose in 24 hrs = 15mg (equivalent to 6 PRN doses)	10mg subcut in 24 hr syringe driver (plus PRN midazolam)	**PRN if needed** 2.5 to 5mg subcut 2 hourly **Syringe driver if needed** 10 to 20mg in CSCI over 24hrs	**10 amps of 5mg/1mL (non-PBS)** (Private Community or FWLHD Hospital Script)	• Use in syringe driver recommended due to very short half-life
GLYCOPYRROLATE/ GLYCOPYRRONIUM	0.2mg/1mL (200mcg/1mL)	**RESPIRATORY TRACT SECRETIONS**	0.2mg subcut 4 hourly PRN max PRN dose in 24 hrs = 1.2mg (equivalent to 6 PRN doses)	1.2mg subcut in 24hr syringe driver (plus PRN glycopyrrolate)	**PRN if needed** 0.2 to 0.4mg subcut 4 hourly **Syringe driver if needed** 1.2mg in CSCI over 24hrs	**30 amps of 0.2mg/1mL (non-PBS)** (Private Community or FWLHD Hospital Script)	• If respiratory tract sections occur, prompt intervention is required • Medications may be ineffective or partially effective; see overleaf and flowchart for advice on non-pharmacological interventions

FOR SPECIALIST PALLIATIVE CARE TELEPHONE ADVICE:

FWLHD Specialist Palliative Care Team: Broken Hill & Disctrict 08 8080 1333 (24hrs) / Dareton 03 5021 7200 (working hours) & 0437 779619 (after hours)

WNSWLHD Specialist Palliative Care Team (during working hours): Dubbo 02 6809 6809 / Orange 02 6369 3000 / Bathurst 02 6330 5000

WNSWLHD (after hours): NSW Health Palliative Care After Hours Helpline 1800 548 225 / Royal Prince Alfred Hospital - Sydney Palliative Medicine On-Call Registrar 02 9515 6111

FWLHD –Anticipatory Prescribing Recommendations for Last Days of Life: SHARE version
Version 3.0 January 2019

ANTICIPATORY PRESCRIBING IN THE LAST DAYS OF LIFE: Prescribing Information

- **All patients in the last days of life should have subcutaneous PRN medications prescribed pre-emptively to ensure that there is no delay in treating the common symptoms that can be anticipated to occur in the last days of life**
- **For patients allergic to or intolerant of recommended last days of life medications, seek advice from Specialist Palliative Care Team**

Recommendations for STARTING doses

- This guide includes the recommended starting dose for first line medications to be pre-emptively prescribed for patients in the last days of life
- Doses should be adjusted up or down to take into account the needs of the individual patient, including frailty and co-morbidities
- Lower starting doses and/or PRN frequencies should be considered in the elderly or in patients with severe renal or hepatic impairment: see advice below for patients with pre-existing end stage kidney disease
- Higher starting doses and/or PRN frequencies can be used if appropriate
- **If required, seek advice from Specialist Palliative Care Team regarding starting doses**

Recommendations for dose TITRATION

- Patients should be assessed regularly, at least every 4 hours or more often if symptomatic
- Response to non-pharmacological interventions and/or PRN medication doses must be assessed following intervention; further management should be instigated if symptom remains despite initial intervention
- Symptom control should be reviewed at least daily, or more often if symptoms are uncontrolled, and background medication doses titrated upwards accordingly
- If >3 PRN doses are required in previous 24 hours and/or symptoms persist, regular medications should be commenced or regular doses increased: see symptom management flowcharts for specific guidance on dose titration for each of the common symptoms
- **Seek advice from local Specialist Palliative Care Team regarding dose titration or if symptoms are non-responsive to dosing and management recommendations in flowcharts**
- **See Palliative Care Therapeutic Guidelines (http://www.tg.org.au) for further prescribing advice**

For patients dying in ICU:

- The existing intravenous route may be preferred over the subcutaneous route for patients with central venous access dying under the care of the ICU setting; all last days of life anticipatory medication recommendations in these guidelines can be intravenously in the ICU setting
- **Seek advice from Specialist Palliative Care Team if required**

Syringe Driver Drug Combinations and Compatibilities

- Compatibility data supports the combination of the last days of life anticipatory medications in a single syringe driver when diluted to maximum volume with 0.9% sodium chloride diluent
- When using alternative medications for symptom control in the last days of life, advice regarding drug compatibility combinations should be sought from a medical officer or specialist nurse with appropriate knowledge and experience prior to administration
- LHD policy and procedure must be followed when prescribing and administering medications via a subcutaneous syringe driver
- **If required, seek advice regarding drug combinations, compatibility data and volumes used in subcutaneous syringe drivers from Specialist Palliative Care Team**
- **See Palliative Care Therapeutic Guidelines (http://www.tg.org.au) for further advice on drug compatibilities**

SPECIALIST PALLIATIVE CARE TELEPHONE ADVICE: see overleaf for FWLHD and WNSWLD contact details

SYMPTOM MANAGEMENT IN THE LAST DAYS OF LIFE: Supporting Information

PRINCIPLES OF SYMPTOM MANAGEMENT IN THE LAST DAYS OF LIFE

- **Assess patient at least every four hours:**
  to allow existing and emerging symptoms to be detected, assessed and treated effectively
- **If symptom(s) present:**
  1. Instigate non-pharmacological measures in the first instance
  2. If non-pharmacological measures ineffective, give PRN medication and review to assess response
  3. If medication ineffective, reassess and instigate further intervention to manage symptom
- **Communicate:** explain likely cause and management of symptom to patient and family
- **Escalate: seek advice from Specialist Palliative Care Team if symptoms remain uncontrolled**

PAIN – see CEC Last Days of Life Toolkit Symptom Management flowchart

- **Non-pharmacological measures:**
  - Ensure comfortable position; consider repositioning and/or alternative mattress
  - Exclude and manage other causes of pain and distress (e.g. urinary retention, anxiety, fear) if present
- **For opioid naive patients** (not on regular opioid in last 7 days):
  - See prescribing guide overleaf for starting doses for PRN and regular subcut morphine(or fentanyl if eGFR < 30)
- **For patients taking regular oral opioids:**
  - Regular oral opioid medication should be converted to the subcut route when unable to swallow or tolerate oral medication in the last days of life
  - See opioid conversion tables on reverse of pain management flowchart for guidance on converting oral to subcutaneous opioids in the last days of life
- **For patients on transdermal buprenorphine or fentanyl patches:**
  - **LEAVE THE PATCH IN SITU, prescribe at same dose and change as usual**
  - See pain management flowchart for guidance on PRN dose of subcut morphine to prescribe
- **If patients demonstrate opioid side effects or show clinical features of opioid toxicity:**
  - **Do NOT give an opioid antagonist** (such as naloxone), as this will precipitate uncontrolled pain and/or opioid withdrawal symptoms
  - **Seek URGENT advice from Specialist Palliative Care Team**

BREATHLESSNESS – see CEC Last Days of Life Toolkit Symptom Management flowchart

- Breathlessness is often associated with significant anxiety in the last days of life
- Non-pharmacological measures:
  - Reassure the patient and family with explanation of cause and management
  - Position to maximise comfort and airway
  - Use a fan and/or an open window
  - Maintain a calm environment

RESTLESSNESS and/or AGITATION – see CEC Last Days of Life Toolkit Symptom Management flowchart

- Restlessness and agitation are COMMON symptoms that occurs in the last days of life
- **Non-pharmacological measures should be considered before medications are introduced:**
  - Exclude urinary retention; manage with catheterisation if present
  - Exclude constipation; consider management with rectal laxatives if present
  - Exclude alcohol/nicotine/illicit drug withdrawal; consider management/nicotine replacement therapy
  - Assess for emotional, psychological and existential distress; address appropriately if present

RESPIRATORY TRACT SECRETIONS – see CEC Last Days of Life Toolkit Symptom Management flowchart

- Respiratory tract secretions are a normal part of dying process; they are not distressing to the patient, but often are for family and carers
- **Non-pharmacological measures:**
  - Reassure family with explanation of the symptom, cause, & measures taken used to relieve secretions
  - Position patient semi-prone and on to alternate sides to encourage postural drainage
  - Suction is NOT RECOMMENDED for respiratory tract secretions and can be distressing to the patient
- Antisecretory medications can be used, but may be ineffective or only partially effective

NAUSEA and/or VOMITING – see CEC Last Days of Life Toolkit Symptom Management flowchart

- **Non-pharmacological measures:**
  - Regular and effective mouthcare; Sips of water and ice chips; Provision of tissues and vomit bag
- Nausea and/or vomiting can have multiple causes (i.e. gastrointestinal, central nervous, intracranial, vestibular and psychological) – see Palliative Care Therapeutic Guidelines (http://www.tg.org.au) for detailed information and medication recommendations for specific causes
- **Seek advice from Specialist Palliative Care Team regarding use of alternative antiemetics**

For further symptom management and prescribing advice, see Palliative Care Therapeutic Guidelines (http://www.tg.org.au)