Cases
Symptom Control
& Last days of life

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For Patients, Families and Bristol

Aims and Objectives

Anticipatory Prescribing and symptom control in last days

Brief overview

Case based discussion

Your questions/cases/other priorities

Anticipatory Prescribing-Principles

Last weeks of life:

- Recognise deterioration, assess, communicate and plan.
- Prescribe 4 PRN sc meds for 5 symptoms 'just in case' (at least 10 vials)
- Authorise for DNs PRN.

Approaching last days of life:

- Authorise all 4 medicines for syringe driver 'just in case'
- Authorise 'appropriate ranges'
- For opioid or midazolam: allow for 2-4 PRN doses
- e.g Morphine 30-40mg or 30-50mg

Incompatibilities:

- Cyclizine is incompatible in a driver with: 1) Buscopan
- 2) Oxycodone at high doses

Anticipatory prescribing -some problems

LCP review: concern over ‘routine’ use opioids and sedation. Critical of ‘one size fits all’ approach

Ranges: diamorphine 10-100mg for a patient on 20mg BD of morphine.

Competence of community nursing staff: Patient given midazolam 10mg as a stat when it was actually written up for a syringe driver (also paperwork issue).

Reversible factors. Patient admitted to hospice for terminal care, midazolam had been started for ‘agitation’. Diagnosed UTI, patient improved went home.

Anticipatory prescribing -some problems

Paperwork, variation, lack of clarity, time consuming for DNs. Hospital discharges.

Pre-printed sheets: patient came home with fentanyl from hospital because stage V renal failure. GP put in pre-printed authorisation sheet, with diamorphine but no prescription. Patient could not be given analgesics.

Anti-emetics better to be specific? E.g. metoclopramide for partial bowel obstruction. Cyclizine and buscopan often prescribed but incompatible. Caution in Parkinson's :avoid metoclopramide/haloperidol.

Anticipatory Prescribing Project

New Community Palliative Care Drug Chart

For authorisation of injectable palliative care medication (PRN and Syringe driver)

Now in use in Bristol, S.Glos and N.Somerset

EMIS version

New patient leaflet with sticky label

New 2 page guidance to standardise practice

New Policy

Emphasis on PRNs only in last weeks

Authorise syringe pump approaching last days

Morphine 1st line as cost saving

Community Palliative Care Drug Chart

- PRNs and driver separate sections to avoid drivers being authorised too early
- Recording of administration much clearer and less time consuming for nurses.
- Pre printed diluent box so not forgotten
- Syringe driver section: can specify if drug is ‘start when needed’ or start today.
- Easier to see at a glance what patient has had
- Designed so can accompany patient on hospital/hospice discharge
- Prescribing table and cautions

Feedback District Nurses

"Charts are brilliant ... really good having a policy to direct GPs to and guidance notes are helpful and contacts written on the chart ..yes as I said brilliant"
Senior Staff Nurse, Bristol Community Health

" The charts and policy an improvement ... I think the anticipatory prescribing in our area has improved as a consequence"
District Nurse Team Leader, Bristol Community Health

" The new policy and charts are much easier ... there is less chance for errors"
District Nurse Team Leader, Bristol Community Health

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Case

Case

What are the possible causes of his symptoms?

What issues might you want to discuss with Mark and Ann?

What changes in medication might you make now?

What else might you do?

Consider treatable reversible causes

Exclude treatable reversible causes

- Is treatment appropriate?
- Would patient want treatment?
- Hypercalcaemia
- Hyperglycaemia
- Infection
- Cord Compression
- Opioid toxicity
- Raised intracranial pressure
- Renal failure

Case

Are there any other issues you would address?

What medication might you consider now?

Recognise, Communicate, Involve, Support, Plan and Do*

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Recognise, Communicate, Involve (Assess) Support

Recognise approaching last days: exclude reversible factors

Communicate with patient involve and support family/carers

Assess symptoms, insight, preferred place of care

Communicate with out of hours

EOL register/electronic palliative care co-ordination system /special note

Religious & spiritual needs

***Leadership alliance for the care of dying people 2014**

Plan ahead

Plan and Do*

Appropriate equipment, care

Who else ....?

Numbers for family to call

Anticipatory prescribing

Discuss and record CPR status

fax form to ambulance service

Bereavement planning/who to call/coroner?

*Leadership alliance for the care of dying people 2014

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NICE guidelines: last days of life

- Recognising when a person may be in last days of life
- Communication
- Shared Decision making
- -individualised care plan
- Maintaining Hydration
- -support the oral route, mouth care
- -??trial of Clinically assisted hydration for thirst
- Pharmacological interventions
- Anticipatory prescribing-individualised not proforma

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Case : PRN SC drugs

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Case : PRN SC drugs

Drug	PRN Dose/frequency
Morphine	15mg-20mg sc hourly Pain/SOB (15mg/ml x 10 vials)
Metoclopramide	10mg 8hrly (10 vials)
Midazolam	2.5-5mg sc hourly agitation (10mg/2mls: 10 vials) 10mg sc stat for seizure
Hyoscine Butylbromide	20mg 2 hourly secretions (20mg/2mls: 10 vials)

- Remember Cyclizine and HBB not compatible.
- If choose Cyclizine then use Hyoscine Hydrobromide.

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Recognise the Terminal Phase

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Recognise the Terminal Phase

Estimate the rate of deterioration: hours/days/weeks?

Views of relatives/carers

In cancer patients who were thought to be dying with 2 of the following (put on ICP)

bedbound

only able to take sips fluid

semi-comatose

can no longer take tablets

time to death was on average ? Days

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Other prognostic indicators?

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Other prognostic factors

Performance status/function-trajectory

Dyspnoea

Oedema

Anorexia

Delirium

Low lymphocyte count

High White cell count

Low albumin

Tool developed 'PiPs' BMJ app/computer algorithm no better than multi-professional opinion.

Prognostication paper GSF web site

BMJ 2011;343:d4920

Case

What SC PRN and syringe driver medication would you prescribe/authorise (include ranges if appropriate)

Is there any other medication you would consider?

Case: syringe driver medications

Drug	Dose in driver	PRN Dose/frequency
Morphine	90mg-120mg (or 150mg)	15mg-20mg sc hourly Pain/SOB
metoclopramide	30-60mg	10mg 8hrly
Midazolam	20-30mg (or 40mg)	2.5-5mg sc hourly agitation 10mg sc stat for seizure
Hyoscine Butylbromide	60-100mg	20mg 2 hourly secretions
Dexamethasone	6.6mg sc OD	Regular chart

3.3mg/ml (or 3.8mg/ml) equivalent to 4mg PO

Enough for at least 3 days plus prns

Think about morphine strengths

- Prescribe 30mg/ml for driver and prns,
- but also provide some 10mg/ml vials for flexibility with prns.

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Case

What opioid would you have authorised prn and in driver for a patient with normal renal function who had been on:-

Fentanyl patch 50microgram/hr?

Oxycontin 60mg BD?

Case

Fentanyl patch 50microgram/hr?

50microgram patch=90x2 =180mg of oral morphine

Divide by 2 = 90mg of morphine/24h

Prn dose 90mg/6 =15mg morphine sc (15-20mg)

Range for driver 30-60mg (2-4 PRN doses)

Oxycontin 60mg BD?

24 hour Po Oxycontin 120mg

divide by 2=60mg sc oxycodone/24 hours (range 60-80/60-100mg)

60mg/6 =10mg sc oxycodone prn hourly

Prescribing in Specific circumstances

Fits: If already on anticonvulsants routinely prescribe midazolam 20-30mg/24hrs via driver for use when unable to take orals. If small/frail start with 10mg/24hrs

PRN 10mg sc/buccal (5mg if frail)

Steroids: consider stopping or reducing depending on how long they have been taking. However maintain if providing symptom control. PO~=sc dose 4mg ~=(3.3mg/ml or 3.8mg/ml)

Ideally prescribe as once a day stat sc in am

Doses above 6.6/7.6mg (2mls) will need to be given in a separate syringe driver/24hours

Caution with anti-emetics in Parkinson’s

Fentanyl Patches

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Fentanyl Patches

Do not initiate in terminal phase

Do not discontinue in terminal phase top up with sc morphine

Appropriate for stable pain

May take up to 72 hours to reach full analgesic efficacy

Patch strength is in mcg/hr

24 hour dose equivalent of '25' fentanyl patch

600mcg fentanyl= 60-90mg oral morphine= 30-45mg SC morphine/24hrs

PRN dose is 30mg-45mg/6 =5mg-7.5mg morphine

-authorise driver with a range of 2-4 breakthrough doses e.g. 10-20mg or 15-30mg

For Buprenorphine 35 patch prn sc morphine ~5mg

PRN opioid and titration

Prescribe PRN s.c opioid hourly for pain at 1/6th of 24 hr sc dose

If more than 2 doses of opioid in 24hours add these into the syringe driver (ensure you are using the s.c dose equivalent)

If not using prn opioids but in pain increase 24 hour opioid by 30%

After increasing 24 hour sc opioid ensure you recalculate the PRN dose.

Remember different strengths of morphine. Highest dose of morphine injection possible is 60mg prn (2mls of 30mg/ml)

Reassess the whole patient if pain worsening or not responding

Summary

Recognise, communicate, involve, support

Plan ahead

Prescribe in advance

Calculate carefully

Liaise with DNs

Use local resources –hospices happy to advise

Questions?

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