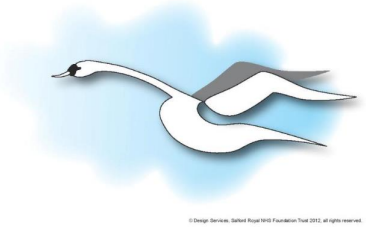
Patient's First Name:	Last Name:
Date of Birth:	NHS Number:

The Shrewsbury and Telford Hospital NHS Trust | Severn Hospice | Shropshire Community Health NHS Trust

End of Life Care Plan

Caring for Adults in the last few hours and days of life



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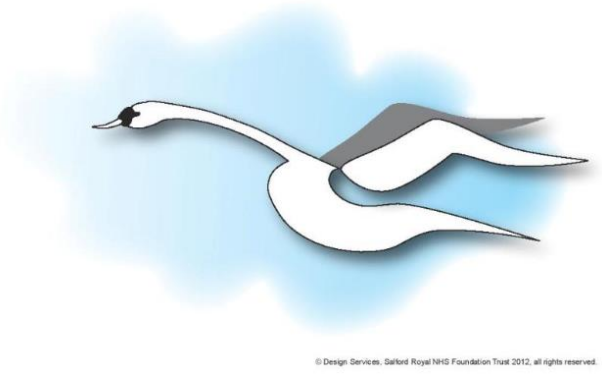
This End of Life Plan has been created to address the holistic needs of the dying person by providing supportive and compassionate person-centred care. It is imperative that all treatment and care provided is of the highest standard and quality. This care must be respectful and dignified and delivered by all involved in a spirit of cooperation and collaboration. The dying person and their family must be at the centre of all care provided. To achieve this, the principles of dignity conserving care[1] will be adopted to guide all decisions and care provided.



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Patient's First Name:	Last Name:
Date of Birth:	NHS Number:

Diagnosing Dying and using the End of Life Care Plan to support care in the last hours or days of life

Assessment

Deterioration in the patient's condition suggests that the patient could be dying – patient may be drowsier, less communicative, and unable to swallow easily, observations may be deteriorating

Clinical Decision

Multidisciplinary Team (MDT) assessment

- Is there a potentially reversible cause for the patient's condition eg exclude opioid toxicity, renal failure, hypercalcaemia, infection
- Could the patient be in the last hours or days of life?
- Is specialist referral needed? Eg specialist palliative care or a second opinion?

Patient is NOT diagnosed as dying (in last hours or days of life)

Patient is diagnosed as dying (in the last hours to days of life)

Communication

Review current plan of care, escalate care as appropriate and communicate new plan to patient and relatives

Patient, relative or carer communication is focused on recognition & understanding that the patient is dying

Discussion with the patient, relative or care (IMCA if lacks mental capacity and is un-befriended) to explain the use of the End of Life Care Plan

Management

The End of Life Care Plan should be used to support care of the patient and family on the ward, in their care home or in their own home

Reassessment

The use of the End of Life Care Plan should guide care and the patient's condition should be regularly reassessed – see Page 8 for more details of reassessment

Further help and advice on caring for dying patients is available from Severn Hospice

01743 236565 & 01952 221350.

Their nurses and doctors are available 24 hour per day.

Patient's First Name:	Last Name:
Date of Birth:	NHS Number:

Initial Assessment: The decision to use the End of Life Plan should be made by the team in charge of the patient's care. For patients at **home or Community Hospital**, this plan can be initiated by the Nurse and/or Therapist/GP who are the key professionals involved in the persons care. The plan then needs to be completed and signed in conjunction with the patient's GP and the copy kept in the person's home. The Shropshire EOL plan should replace all other documentation used. The practice computer should be used to record additional information. In **residential or nursing homes** the End of Life Plan should be completed by a GP and senior nurse/care manager. In **hospice or hospital** this plan should be completed by a senior doctor at registrar level or above in conjunction with the most senior nurse on the ward, usually a ward sister or charge nurse. **Discussions with the patient and their relatives should be recorded in full.** In hospital this document should be completed and filed in the current admission sections of the medical records and/or within nursing documentation; in the community kept within patients' homes and in care homes within patient records.

Date of decision to use this plan: _____ **Time**: _____

Name/Signature and grade of decision makers: _____

_____

Name of person completing document: _____ **Grade:** _____

Name of Consultant (if in hospital) or GP if different from above: _____

Informed Yes □ **Date and Time:** _____

(Please make the patient's usual team aware at earliest convenience)

Up-to-date contact information for the relative/carers

1st contact name: _____ Relationship **to patient**: _____

Tel number: _____ **Mobile:** _____

Contact: At any time □ Not at night time □ Staying with patient overnight □

2nd contact name: _____ **Relationship to patient**: _____

Tel number: _____ **Mobile:** _____

Contact: At any time □ Not at night time □ Staying with patient overnight □

Lasting Power of Attorney (Health) Yes ☐ No ☐

Main diagnosis if known:

Comments:

Patient's First Name:	Last Name:
Date of Birth:	NHS Number:

Patient's preferred place of care (home, hospital, hospice, care home, other) discussed with patient and family/carers, and discharge home has been considered if patient is in hospital. *If in hospital and wishing to go home for end of life care consider **fast track** checklist, communication with **pharmacy** re medication for discharge and **ShropDoc** Flagging for out of hours service.*

Do Not Resuscitate decision

Advance care planning reviewed Yes ☐ No ☐

Do Not Resuscitate (DNR)/Allow Natural Death (AND) form already completed ☐

DNR/AND form completed now ☐

Advance directive completed ☐

Lasting power of attorney (Health or Welfare) ☐

Implantable Cardioverter Defibrillators (ICD) if present needs to be deactivated – contact cardiorespiratory at PRH or RSH or CCU out of hours via the hospital switchboard RSH 01743 261000, PRH 01952 641222.

Artificial Hydration and Nutrition

Support the patient to take fluids by mouth for as long as they can. For most patients the use of artificial hydration and nutrition will not be required. A reduced need for fluids is part of the normal dying process and should be explained to patients and relatives. Any artificial hydration and nutrition eg NG or PEG feeds should be discontinued or reduced when patients are dying. Patients should be supported to eat as they feel able.

Good mouth care is essential. Symptoms of thirst or dry mouth do not always indicate dehydration but are often due to mouth breathing or medication.

Decision made at time of initial assessment that clinically assisted hydration is:

Not required ☐ **Discontinued** ☐ **Continued** ☐

Rationale and explanation discussed with patient and/or family ☐

If being used consider reduction in rate/volume according to individual need. If required consider the s/c route and please briefly document reasons for decision.

Patient's First Name:	Last Name:
Date of Birth:	NHS Number:

Discontinuing Inappropriate Interventions

	Currently not being taken/given	Discontinued	Continued
Routine blood tests	☐	☐	☐
Intravenous therapies	☐	☐	☐
Blood glucose testing	☐	☐	☐
Recording vital signs ('observations')	☐	☐	☐
Oxygen therapy	☐	☐	☐
Non-palliative medications	☐	☐	☐
Intravenous re-cannulation	☐	☐	☐

Anticipatory Prescribing

Anticipatory prescribing will ensure that there is no delay in responding to a symptom if it occurs *(refer to the flow charts at the end of the plan for more guidance)*.The patient should have medication prescribed on an as needed basis for all of the following symptoms which may develop in the last hours or days of life:

Pain ☐ Diamorphine 2.5-5mg s/c PRN if opioid naive

Agitation ☐ Midazolam 2.5-5mg or Haloperidol 2.5mg s/c PRN

Respiratory secretions ☐ Hyoscine Butylbromide 20mg s/c PRN

Nausea/vomiting ☐ Levomepromazine 6.25mg s/c PRN

Breathlessness ☐ Diamorphine 2.5-5mg +/- Midazolam 2.5-5mg s/c PRN

If a T34 (syringe pump) is to be used explain the rationale to the patient and/or family or carer. In the community complete the syringe pump sheet. Not all patients who are dying need a syringe driver. If medicines are issued in the community to a patient in advance of deterioration in their condition 'just in case' then the community prescribing sheet must be completed by the prescriber assessing the patient when the decision is made to initiate the drugs.

Patient's First Name:	Last Name:
Date of Birth:	NHS Number:

Spiritual and Religious Beliefs

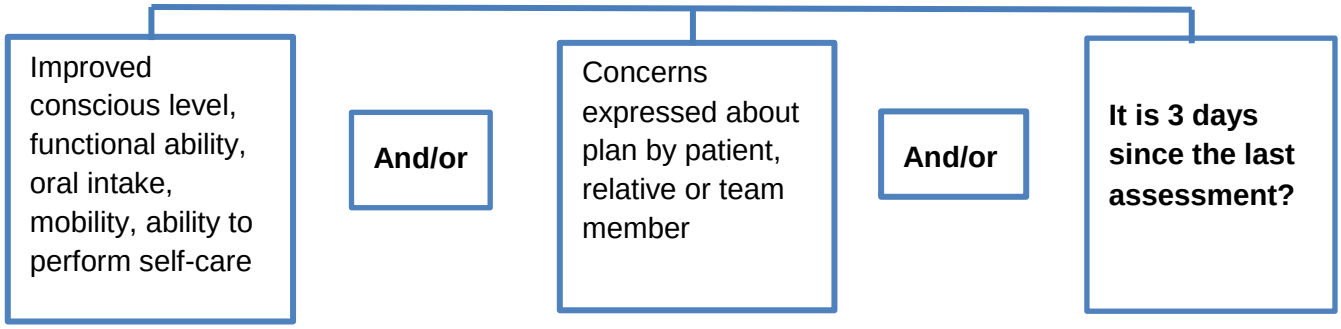
Spiritual issues may involve exploring personal, religious or spiritual beliefs including questions of faith, in self, others and for some people this may include belief in God, deity or higher power. Therefore, with the consent of the patient/next of kin, there may be a need to refer to the person's own religious/faith representative or chaplain. Spiritual issues may also involve questions about hope, trust, meaning, purpose and forgiveness. It may require discussion about peoples' values, love and relationships and questions about morality or what is fundamental to the preservation of their dignity and self-identity. Spiritual issues may also be expressed through creativity such as art, music and poetry.

Please document any spiritual issues or personal wishes here

Patient's First Name:	Last Name:
Date of Birth:	NHS Number:

Repeat Assessment

Undertake an MDT assessment & review of the current management plan if:



Consider the support of the specialist palliative care team and/or a second opinion as required. Document re-assessment dates and times in the medical and nursing notes. Please use the nursing continuation sheets for the End of Life Care Plan if the patient is being looked after at home.

If the patient improves and is no longer expected to die within the next few days then the End of Life Care Plan should be discontinued.

Date and Time End of Life Care Plan discontinued: _____/_____/_____ at _____

Reasons End of Life Care Plan discontinued:

_____

_____

_____

Name: _____

Signature: _____

Patient's First Name:	Last Name:
Date of Birth:	NHS Number:

Current Issue - Day 1 **Date** _____

Pain		Difficulty swallowing	
Agitation		Constipation/faecal incontinence	
Nausea and Vomiting		Oral care	
Breathlessness		Urinary incontinence/retention	
Respiratory Tract Secretions		Confusion/delirium	
Elimination/Catheter		Pressure Areas/immobility	
Communication with family		Personal hygiene	
Anxiety/Psychological Support		Pressure sores	

Date & Time		Signature

Patient’s First Name:	Last Name:
Date of Birth:	NHS Number:

Date & Time		Signature

Patient's First Name:	Last Name:
Date of Birth:	NHS Number:

Current Issue - Day 2 **Date** _____

Pain		Difficulty swallowing	
Agitation		Constipation/faecal incontinence	
Nausea and Vomiting		Oral care	
Breathlessness		Urinary incontinence/retention	
Respiratory Tract Secretions		Confusion/delirium	
Elimination/Catheter		Pressure Areas/immobility	
Communication with family		Personal hygiene	
Anxiety/Psychological Support		Pressure sores	

Date & Time		Signature

Patient's First Name:	Last Name:
Date of Birth:	NHS Number:

Date & Time		Signature

Patient's First Name:	Last Name:
Date of Birth:	NHS Number:

Current Issue - Day 3 **Date** _____

Pain		Difficulty swallowing	
Agitation		Constipation/faecal incontinence	
Nausea and Vomiting		Oral care	
Breathlessness		Urinary incontinence/retention	
Respiratory Tract Secretions		Confusion/delirium	
Elimination/Catheter		Pressure Areas/immobility	
Communication with family		Personal hygiene	
Anxiety/Psychological Support		Pressure sores	

Date & Time		Signature

Patient's First Name:	Last Name:
Date of Birth:	NHS Number:

Date & Time		Signature

Patient's First Name:	Last Name:
Date of Birth:	NHS Number:

Current Issue - Day ___ **Date _____**

Pain		Difficulty swallowing	
Agitation		Constipation/faecal incontinence	
Nausea and Vomiting		Oral care	
Breathlessness		Urinary incontinence/retention	
Respiratory Tract Secretions		Confusion/delirium	
Elimination/Catheter		Pressure Areas/immobility	
Communication with family		Personal hygiene	
Anxiety/Psychological Support		Pressure sores	

Date & Time		Signature

Patient's First Name:	Last Name:
Date of Birth:	NHS Number:

Date & Time		Signature

Patient's First Name:	Last Name:
Date of Birth:	NHS Number:

Care After Death

Verification of Death (please document here if patient dies at home or in a nursing/residential home, otherwise use the medical notes)

Date of patient's death: _____/_____/_____ Time of patient's death:_____

Details of Healthcare Professional who verified death:

Name: _____ (please print)

Position: _____

Signature: _____

Contact telephone number: _____

Comments: _____

_____

Persons present at time of death: _____

_____

Relative / Carer present at time of death: Yes ☐ No ☐

If not present, have they been notified: Yes ☐ No ☐

Any special requirements after death?

Eg. any cultural or religious requirements

'What to do after a death' or equivalent booklet given to relative: **Yes ☐ No ☐**

Verification of Death carried out as per policy and documentation completed. **Yes ☐**

Verification/Certification Date: _____ Time: _____

Patient's First Name:	Last Name:
Date of Birth:	NHS Number:

Personal care after death performed as per care after death policy with respect and maintaining dignity incorporating religious/cultural considerations?

Comments:

_____

_____

_____

_____

_____

_____

Has any jewellery been left on the body?

Yes ☐ **No ☐**

Comments/Descriptions:

_____

_____

_____

Is there any requirement for the medical team to inform/discuss with the Coroner's office?

Yes ☐ **No ☐**

If yes, comments:

_____

_____

Patient Name..... DOB.....

NHS Number.....

The bereavement booklet has been shared with Family or Carers and the next steps talked through?

Comments:

_____

_____

_____

_____

Patient's First Name:	Last Name:
Date of Birth:	NHS Number:

Have the patient's property and valuables are returned as per property policy? **Yes ☐**

Comments: _____

_____

_____

_____

Have the family been given death certificate?

Yes ☐ **No ☐**

Comments: _____

_____

_____

_____

Funeral Director information provided by family (include contact details):

_____

_____

_____

_____

Patient Name..... DOB.....

NHS Number.....

If patient is for cremation, paperwork completed:

◯ Part 1 ◯ Part 2

Have the patient's family/NOK been offered the opportunity to see the person after death?

Comments:

_____

_____

Patient's First Name:	Last Name:
Date of Birth:	NHS Number:

Information sheet for relatives following a discussion about end of life care

The doctors and nurses will have explained to you that there has been a change in your relative's condition. They believe that they are now in the last hours or days of life.

The End of Life Plan helps doctors and nurses to give the best care to your relative. You will be involved in the discussion regarding the plan of care with the aim that you fully understand the reasons why decisions are being made. If your relative's condition improves then the plan of care will be reviewed and changed.

Communication-Written information leaflets like this one can be useful, as it is sometimes difficult to remember everything at this time. The doctors and nurses will ask you for your contact details, as keeping you updated is a priority. There is space at the bottom of this leaflet to jot down any questions you may have for the doctors and nurses.

It can be very difficult to predict precisely when someone who is dying will pass away. For some relatives and friends it is very important that they are present at the moment of death. Others will feel they have already said their goodbyes. Please let us know your specific wishes so that we can try and ensure that they are carried out.

Medication-Medicine that is not helpful at this time may be stopped. People often find it difficult to swallow lots of tablets. Some new medicines may be prescribed and these are often given as a small injection under the skin. Medicines for treating symptoms such as breathlessness, pain or agitation will be given when needed. Sometimes they can be given continuously in a small pump called a syringe pump, which can help to keep patients comfortable.

Reduced need for food and drink-Loss of interest in eating and drinking is part of the dying process and it can sometimes be hard to accept. Your relative will be supported to eat and drink for as long as they want to.

If a patient is in hospital and cannot take fluids by mouth, a drip may be considered, or may have been started before it became clear that your loved one is dying. Fluids given by a drip will only be used where it is helpful and not harmful. These decisions will be explained to your relative or friend if possible and to you.

Good mouth care is very important at this time and can be more important than fluids in a drip in terms of feeling comfortable. The nurses will explain to you how mouth care is given and may ask if you would like to help them give this care.

Changes in breathing-When someone is dying, their need for oxygen may lessen and the way they breathe may change. People who have been breathless may feel less breathless at this time. Their breathing may pause for a while and then start again. They use different muscles to breathe, which means their breathing may look different. Sometimes breathing can sound noisy or "rattling" because the person is no longer able to cough or clear their throat. This can sound upsetting but is generally not distressing for them.

Changes in how the person looks and behaves-During the process of dying, a person's skin may become pale and moist. Their hands and feet can feel very cold and sometimes look bluish in

colour. Dying people often feel very tired and will sleep more. Even when they are awake, they may be drowsier than they have been and they will be awake less and less. They may still be aware of the presence of family and friends so you can still talk to them.

Support for family and friends- It is sometimes easier to cope with things at this difficult time if you have someone outside your immediate family to talk to. For patients at home or in a residential home, the District Nurses, patient's GP and Macmillan nurses can offer support. For patients in a nursing home the home's nurses along with the patient's GP will offer care and support and will have arrangements with various faith representatives to provide further comfort and support. For patients in hospital or in the hospice, the ward nurses can support you or contact the Specialist Palliative Care Team. The hospital chaplaincy is also very happy to offer comfort and support to people of all faiths or none, and can be contacted by the ward nurses or doctors.

Caring well for your relative or friend at the end of their life is very important to us.

Please speak ask any questions that occur to you, no matter how insignificant you think they may be.

Other information or contact numbers:

……
……
……
……
……
……
……

This space can be used for you to list any questions you may want to ask the doctors and nurses:

……
……
……
……
……
.....

Prescribing Guidance for Dying Patients

Severn Hospice

Most patients are comforted by the knowledge that medication is helpful and available if required at the end of their life.

The following flow charts are to be used as guide for patients in their last hours of life. Further information is available from the West Midlands Palliative Care Physicians "Guidelines for the use of drugs in symptom control" www.wmpcg.co.uk and the Palliative Care Formulary.

Please follow the below link for Opioid Conversion Guidance and other useful information.

http://www.severnhospice.org.uk/for-healthcare-professional/gp-info-hub/

Review drug/dose/frequency for patients who are Elderly, Frail, have Dementia or Renal Failure and seek advice.

PAIN AT THE END OF LIFE

Is patient already on opioid drugs and unable to tolerate or absorb oral medication?

YES

Patient on MR Morphine/Oramorph

- Divide 24 hour total dose of current **oral** Morphine by 3 and prescribe this as Diamorphine (mgs) via syringe pump over 24 hours
- Prescribe 1/6th Diamorphine syringe pump dose for breakthrough/rescue medication to be given hourly if needed
- Start syringe pump 4 hours before next oral opioid dose would have been due
- Discontinue oral opioid

Review within 24 hours
If extra medication has been needed for pain:

- Increase syringe pump dose by total amount of rescue Diamorphine given or by 50%, whichever is less
- Adjust rescue/breakthrough dose to 1/6th of syringe pump Diamorphine dose to be given hourly if needed

If pain is controlled, make **NO** changes
Continue to review dose requirements regularly

Patient on weak opioid (Codeine, Tramadol, Dihydrocodeine)

- Stop oral weak opioid
- Start diamorphine 10mg/24hrs by syringe pump soon after last oral dose
- Prescribe Diamorphine 2.5mg subcut hourly if needed for rescue/breakthrough pain

Review regularly and adjust as above

Fentanyl patch: continue patch and supplement with subcut Diamorphine hourly as needed and add in a syringe pump if needed
Renal impairment: if GFR <30 seek advice

NO

Scenario 1: "planning ahead"
Patient not in pain

- Prescribe Diamorphine 2.5-5mg subcut hourly if needed
- If patient later develops pain, proceed to next box

Scenario 2: "act now"
Patient in pain

- Given Diamorphine 2.5mg subcut stat
- Prescribe and start Diamorphine 10mg/24h by syringe pump
- Prescribe Diamorphine 2.5mg subcut for rescue/breakthrough pain to be given hourly if needed

Review within 24 hours
If extra medication has been needed for pain:

- Increase syringe pump dose by total amount of rescue medication given or to 20mg/24hrs, whichever is less
- Increase rescue/breakthrough dose of Diamorphine to 5mg subcut to be given hourly if needed

If pain is controlled, make **NO** changes

Review within 24 hours
If extra medication has been needed for pain:

- Increase syringe driver pump by total amount of rescue Diamorphine given or by 50%, whichever is less
- Adjust rescue/breakthrough dose to 1/6th of syringe driver pump Diamorphine dose to be given hourly if needed

If pain is controlled, make **NO** changes
Continue to review dose requirements regularly

If symptoms persist or you need advice please contact the Palliative Care Team or Severn Hospice

NAUSEA AND/OR VOMITING AT THE END OF LIFE

Important note: this guidance applies to the end of life ONLY

Effective palliation of nausea and vomiting earlier in the illness requires a cause-specific approach

Patients entering the terminal phase with **good symptom control** from an oral anti-emetic should **continue the same drug** given via syringe pump when they are unable to take oral medication. Domperidone should be replaced by Metoclopramide and Prochlorperazine (stemetil) by Cyclizine.

For **new symptoms of nausea or vomiting** that are difficult to control, Levomepromazine* (Nozinan) is recommended because of its broad spectrum of action.

Patient has new of uncontrolled nausea and/or vomiting

Give Levomepromazine 6.25mg subcut stat (a once daily dose may be sufficient because of its long half-life)

Also prescribe Levomepromazine 6.25mg subcut as needed.
Dose may be repeated after 1 hour
If repeat dose is needed, initiate syringe pump

In some settings, eg community, it may be appropriate to give a stat dose of Levomepromazine subcut AND start a syringe pump with Levomepromazine at the same time

Levomepromazine by syringe pump

- Start at 6.25mg – 12.5mg/24 hours

Patient has no nausea/vomiting OR controlled on existing medication

Prescribe Levomepromazine 6.25mg subcut as needed in case nausea/vomiting become a problem in the terminal phase.
This can be repeated after 1 hour if needed.

If 2 or more doses are needed in 24hrs, start syringe pump with Levomepromazine 12.5mg/24hrs.

Continue Levomepromazine 6.25mg subcut as needed, leaving 1 hour between doses (max 4 doses). If 1 or more extra doses needed in 24 hrs increase syringe pump to 25mg/24hrs.

If nausea and/or vomiting are not controlled adequately at any stage, contact palliative care team for advice

*** Levomepromazine doses above 25mg/24hr have a sedative effect**

If symptoms persist or you need advice please contact the Palliative Care Team or Severn Hospice

RESTLESSNESS/AGITATION AT END OF LIFE

Consider and manage **common causes of restlessness** eg Urinary retention, faecal impaction, hypoxia and pain.

Patient is restless or agitated

Patient is not restless or agitated

Non-drug intervention is essential: reassurance, calm environment, consider the use of music/sound.
Ask: Have their spiritual needs been addressed?

Immediate management
Give medication subcut stat:
Either Midazolam 2.5-5mg
OR
Haloperidol 2.5mg

Planning ahead
Prescribe subcut hourly as needed
Either Midazolam 2.5mg
OR
Haloperidol 2.5mg

Start syringe pump:
Midazolam 10-20mg/24hrs
OR
Haloperidol 5mg/24hrs

Prescribe rescue doses subcut hourly
Midazolam 2.5-5mg
AND/OR
Haloperidol 2.5mg

Review within 24 hours

If >2 doses are needed **and are effective** start a syringe pump with the same drug

If >2 doses are needed **and are not effective** change to the other drug or consider levomepromazine (an effective sedative).

Review within 24 hours

Midazolam:
- 1-2 extra doses, increase syringe pump dose by 50%
- >3 extra doses, double syringe pump dose doses
- Continue rescue doses of 5mg subcut as needed
- If >40mg/24hr, consider levomepromazine with midazolam

Haloperidol:
- Any extra doses, increase syringe pump to 10mg/24hrs and continue rescue doses (max 20mg/24hrs)

Midazolam and haloperidol are very effective in combination

Levomepromazine:

- Consider use of levomepromazine for persistent symptoms.
- Use with midazolam (if midazolam partially effective) or to replace haloperidol
- Do not use with haloperidol

Start syringe pump at 25mg/24hr

Prescribe 12.5mg subcut hourly as needed dose

If symptoms persist or you need advice please contact the Palliative Care Team or Severn Hospice

RESPIRATORY TRACT SECRETIONS IN A DYING PATIENT

Dying patients may be unable to cough effectively or swallow, which can lead to retained secretions in the upper respiratory tract. There is little evidence to support the effectiveness of drug treatment for this symptom. If the patient appears comfortable and not distressed reassure relatives and staff.

Hyoscine Butylbromide, also known as Buscopan, is out drug of choice to use for respiratory tract secretions at end of life.

Hyoscine Butylbromide is non-sedating. It does not mix well with Cyclizine in a syringe and blocks the prokinetic antiemetic action of Metoclopramide.

If rattling breathing is associated with breathlessness in a semiconscious patient add in an opioid +/- an anxiolytic sedative (Midazolam).

SECRETIONS PRESENT

General management
- **Give explanation and reassurances to relatives**
- Alter position to shift secretions
- Discontinue parenteral fluids
- Give hourly mouth care

Drug treatment

Stat dose: Hyoscine Butylbromide 20mg subcut

Start syringe pump: Hyoscine Butylbromide 60mg/24hr

Allow rescue doses of Hyoscine Butylbromide 20mg subcut 2 hourly as needed

Review after 24 hours or sooner
If rescue doses have been needed, increase the syringe pump to Hyoscine Butylbromide 120mg/24hr

If secretions persist, use **Glycopyrrolate 200-400micrograms subcut** as stat doses should be used as 2nd line

SECRETIONS ABSENT

Planning Ahead
Patients may develop respiratory tract secretions

Prescribe Hyoscine Butylbromide 20mg subcut 2 hourly as needed

Review after 24 hours or sooner
If 2 or more doses needed, follow 'secretions present'

In patients with heart failure, consider furosemide 20mg subcut

If symptoms persist or you need advice please contact the Palliative Care Team or Severn Hospice

BREATHLESSNESS AT THE END OF LIFE

Terminal breathlessness is very frightening and must be treated as a serious symptom. Untreated it can lead to escalation of symptoms, distress and terminal agitation.

BREATHLESSNESS PRESENT

‘

General measures

- Calm environment
- Reassurance and support
- Gentle air flow with fan (damp flannel around mouth)
- Cool room
- Given hourly mouth care
- Oxygen if helpful/hypoxic

Use of medication

Patient not on opioid for pain

- Give Diamorphine 2.5mg subcut stat
- Prescribe hourly as needed for rescue dose
- Start Diamorphine

Patient on MR Morphine/Oramorph

- Divide 24 hour total dose of current oral morphine by 3 and prescribe this as diamorphine (mg) via syringe pump over 24 hours
- Prescribe 1/6th diamorphine syringe pump dose for breakthrough/rescue medication to be given hourly as needed
- Start syringe pump 4 hours before next oral opioid dose would have been due
- Discontinue oral opioid

(The above mimics pain flow chart above – if in pain and breathless DO NOT double doses)

Review within 24 hours

If >2 rescue doses needed in 24 hours

- Increase the medication in the syringe pump
- A combination of diamorphine and Midazolam may be needed
- Continue rescue doses hourly as needed

Increase rescue dose of chosen drug to 5mg and continue hourly as needed

BREATHLESSNESS NOT PRESENT

Planning ahead

Patient not on opioid for pain

Prescribe diamorphine 2.5mg subcut hourly if needed

Consider Midazolam 2.5mg subcut hourly if anxiety likely to occur

Review within 24 hours

If 2 or more doses needed, manage as for breathless patient

Consider:

If anxiety continues:

- Midazolam 2.5-5mg subcut hourly as needed

If bronchospasm is a significant factor

- Add inhaler (if appropriate), nebulisers
- Consider use of steroids

If pulmonary oedema is a significant factor

- Furosemide subcut injection (maximum 20mg in 1 site)

Continue to review regularly and modify syringe pump doses as needed (guided by rescue medication required)

If symptoms persist or you need advice please contact the Palliative Care Team or Severn Hospice