HWE ICS End of Life Care Anticipatory Prescribing Guidance

Principles of Anticipatory Prescribing

- This guidance provides **general** recommendations for the pharmacological management of common symptoms in the last days of life.
- Ensure that suitable anticipatory medicines are considered ahead of need and prescribed when appropriate.
- Anticipatory prescribing in this manner will ensure that in the last hours / days of life there is no delay responding to a symptom if it occurs.
- Reversible causes of symptoms should be treated where appropriate.
- Non-pharmacological methods should also be considered e.g. re- positioning to manage respiratory secretions.
- **Involve the dying person and those important to them in making decisions about symptom control in the last days of life where possible.**
- Use an individualised approach to prescribing anticipatory medicines, assessing what medicines the person might need to manage symptoms likely to occur during their last days of life.
- When deciding which anticipatory medicines to offer, take into account:
    - The likelihood of specific symptoms occurring
    - The likely cause of symptoms
    - The benefits and harms of prescribing or administering medicines (e.g. renal or hepatic failure)
    - The benefits and harms of not prescribing or administering medicines
    - The possible risk of the person suddenly deteriorating (e.g. catastrophic haemorrhage or seizures), for which urgent symptom control may be needed
    - The place of care and the time it would take to obtain medicines
- To check syringe pump compatibility, click https://book.pallcare.info
- To check conversion information for oral opioid to parenteral doses, click https://bnf.nice.org.uk/medicines-guidance/prescribing-in-palliative-care/
- Specify the indications for use and the dosage of any medicines prescribed and start with the lowest effective dose.
- Specify an appropriate route for administration. If the person is unable to take or tolerate oral medication, give subcutaneous injections.
- Review symptoms before and after anticipatory medicines are administered and to inform appropriate titration of medicine.
- Monitor for benefits and any side effects at least daily and adjust the individualised care plan and prescription as necessary.

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Specialist Palliative Care Advice

Seek advice if there is uncertainty about the cause of symptoms, if symptoms do not improve with treatment, there are undesirable side effects or higher dose ranges are needed.

Area	Service	Daytime	24/7 Advice
West Essex	St Clare Hospice Princess Alexandra Hospital SPC Team	01279 773773 01279 827846	01279 773773
East Herts	Isabel Hospice	01707 382500	01707 382575
North Herts	Garden House Hospice Care Lister Hospital SPC Team North Herts Community SPC Team	01462 679540 01438 284035 0300 1237571 (HUB)	01462 416794
Hillingdon	Michael Sobell House	0208 1069201	0203 8241268
South West Herts	**Referrals & Advice:** West Herts Palliative Care Referral Centre **Advice:** West Herts Community SPC Team Hospice of St Francis Rennie Grove Peace Hospice Care Watford General Hospital	03332 340868 02081 026236 01442 869550 01923 606030 01923 217930	01923 335356

Medication Supply

Drug	Supply	Strength and Formulation
Cyclizine	Five	50mg/1ml ampoules
Glycopyrronium	Five	200mcg/1ml ampoules
Haloperidol	Five	5mg/1ml ampoules
Hyoscine butylbromide	Five	20mg/1ml ampoules
Levomepromazine	Five	25mg/1ml ampoules
Lorazepam	Five	1mg sublingual tablets
Midazolam (controlled drug)	Five	10mg/2ml ampoules
Morphine sulphate (controlled drug)	Five	10mg/1ml ampoules *if opioid naïve**
Water for injection	Five	10ml ampoules

*Seek advice on appropriate drugs, dose and supply for patients already taking opioids or using alternative opioids e.g. oxycodone

For a list of pharmacies supplying end of life medication click:
https://www.hweclinicalguidance.nhs.uk/all-clinical-areas-documents/download?cid=2832&checksum=2bc8ae25856bc2a6a1333d1331a3b7a6

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Indication	Drug	PRN subcutaneous (s/c) dose	Syringe Pump dose (CSCI* / 24 hours)	Supporting Information *Medication will need to be prescribed according to individual patient needs (age, renal, hepatic function etc*
Pain *If opioid naïve*	Morphine sulphate	2.5 – 5mg s/c 2 hourly (maximum 6 doses in 24 hours)	10 – 20mg / 24 hours	• Treat reversible causes e.g. urinary retention. • Consider co-analgesics e.g. Paracetamol. • In renal failure, liver failure or frailty, please seek specialist palliative care advice regarding appropriate opioid and dose. • If the patient is already on an alternative opioid or analgesic patch seek specialist advice or review opioid conversion guidance. • To switch between opioids refer to the conversion table or contact the specialist palliative care team for advice. • If patient is on a transdermal fentanyl patch leave the patch on and add additional analgesia (if required) in syringe pump. If patient is on buprenorphine patch, seek advice.
Pain *If already on regular morphine*	Morphine sulphate	Divide the total **oral** Morphine dose by 12 *e.g. 30mg MST bd = 60mg divide by 12 = 5mg s/c 2 hourly*	Half of the total oral Morphine dose. *e.g. 30mg MST bd = 30mg Morphine / 24 hours*	
Breathlessness	Morphine sulphate	2.5mg s/c 2 hourly *If opioid naïve*	5-10mg / 24 hours *If opioid naïve*	• Consider non-pharmacological measures (e.g. fan, open window). • Trial oxygen for hypoxaemia and monitor according to response. • Benzodiazepines should only be used to manage anxiety associated breathlessness. • For patients already on regular oral opioids use equivalent prn and syringe pump dose.
	Lorazepam (Genus brand)	0.5mg –1mg **sublingual** 6 hourly (max 4mg in 24 hours)	N/A	
	Midazolam	2.5mg s/c 2 hourly	10-20mg / 24 hours	
Nausea and Vomiting	Cyclizine	50mg s/c 8 hourly (max 150mg in 24 hours)	100-150mg / 24 Hours	• If already on an effective anti-emetic, continue this. • Consider cyclizine where patient not already taking an anti-emetic. • Do not use cyclizine in heart failure - seek specialist advice • Consider metoclopramide for gut related nausea and vomiting. Avoid in complete bowel obstruction. • Consider haloperidol for chemically induced (e.g. drugs) related nausea and vomiting or in renal/hepatic failure. • Haloperidol use is contra-indicated in Parkinson's disease. • Consider levomepromazine if no improvement with metoclopramide/haloperidol/cyclizine.
	Haloperidol	0.5 - 1.5mg s/c stat dose And 2 hourly (max 10mg in 24 hours)	Start with 0.5-1.5mg and titrate up to 10mg / 24 hours	
	Levomepromazine	6.25 – 12.5mg s/c 8 hourly (max 25mg in 24 hours)	5 - 25mg / 24 hours	
	Metoclopramide	10mg s/c 8 hourly (max 100mg in 24 hours)	30 – 100mg / 24 hours	

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Anxiety, Delirium and Terminal Agitation	Haloperidol	0.5 - 1.5mg s/c 2 hourly (max 10mg/24hours) If severe distress, 1.5 – 3mg s/c 3 hourly (max 10mg/24 hours)	1.5-10mg / 24 hours	• Treat reversible causes e.g. pain, urinary retention. • Consider the appropriate level of sedation required. • Benzodiazepines should be used 1st line for agitation with no signs of delirium. • Midazolam should be used before levomepromazine. • Haloperidol should be used 1st line for delirium. • Haloperidol use is contra-indicated in Parkinson's disease. • For terminal agitation consider midazolam alone, or in combination with haloperidol (when prescribed in combination with midazolam, haloperidol dose is 3 – 5mg / 24 hours). If patient not settled, consider levomepromazine. • Seek specialist advice for levomepromazine doses higher than 50mg in 24 hours.
	Lorazepam (Genus brand)	0.5 –1mg **sublingual** 6 hourly	N/A	
	Levomepromazine	12.5 - 25mg s/c 1 - 2 hourly (max 50mg in 24 hours)	12.5 - 50mg / 24 hours	
	Midazolam	2.5 – 5mg s/c 2 hourly	10-30mg / 24 hours	
Noisy Respiratory Secretions	Glycopyrronium bromide	0.2mg s/c 6 hourly (max 1.2mg in 24 hours)	0.6 -1.2mg / 24 hours	• Reposition patient. • Reassure relatives and **only** use medications if secretions are causing distress. • Consider switching / stopping if no benefit after 24 hours. • Anticholinergics reduce the production of secretions and do not remove those already present.
	Hyoscine butylbromide	20mg s/c up to 4 hourly (max 120mg in 24 hours)	20 - 120mg / 24 hours	
Supplementary Prescribing (for patients with specific risk factors only)				
Seizures	Midazolam	10mg s/c (or buccal preparation) stat	20-30mg / 24 hours	• Replace oral anticonvulsive drugs with midazolam syringe pump if no longer able to swallow. • If taking oral steroids for cerebral disease/antiepileptics seek specialist advice on converting to syringe pump.
Severe Haemorrhage	Midazolam	10mg s/c (or buccal preparation) stat	N/A	• Manages distress in acute, severe bleeding. • For on-going bleeding, treat any distress or pain as above.

*CSCI = continuous subcutaneous infusion

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Pain

Is the patient taking oral morphine or other opioid?

Yes

Convert dose of current opioid to 24 hour syringe pump dose of morphine. If pain not controlled, increase dose by a third.

Prescribe PRN dose by dividing the total **oral** morphine dose by 12

(e.g. 30mg MST bd = 60mg, divide by 12 = 5mg s/c 2 hourly)

- Review every 24 hours. If PRN doses required, consider increasing the dose of the infusion.
- Remember to increase the PRN dose if the dose of the infusion is increased.
- PRN dose should be a twelfth of the total **oral** morphine dose in 24 hours.
- Maximum of 6 doses in 24 hours.

No

Prescribe SC morphine 2.5mg - 5mg up to every TWO hours PRN. Maximum 6 doses in 24 hours

Review at least every 24 hours.

If PRN doses have been required consider starting a syringe pump.

Morphine (PO)	Morphine (S/C)	Oxycodone (S/C) (second line – e.g. for renal failure patients)
5mg	2.5mg	1.25mg
10mg	5mg	2.5mg
15mg	7.5mg	3.75 mg
20mg	10mg	5mg
30mg	15mg	7.5mg
Ref: BNF https://bnf.nice.org.uk/medicines-guidance/prescribing-in-palliative-care/ and Palliative Care Formulary v8		

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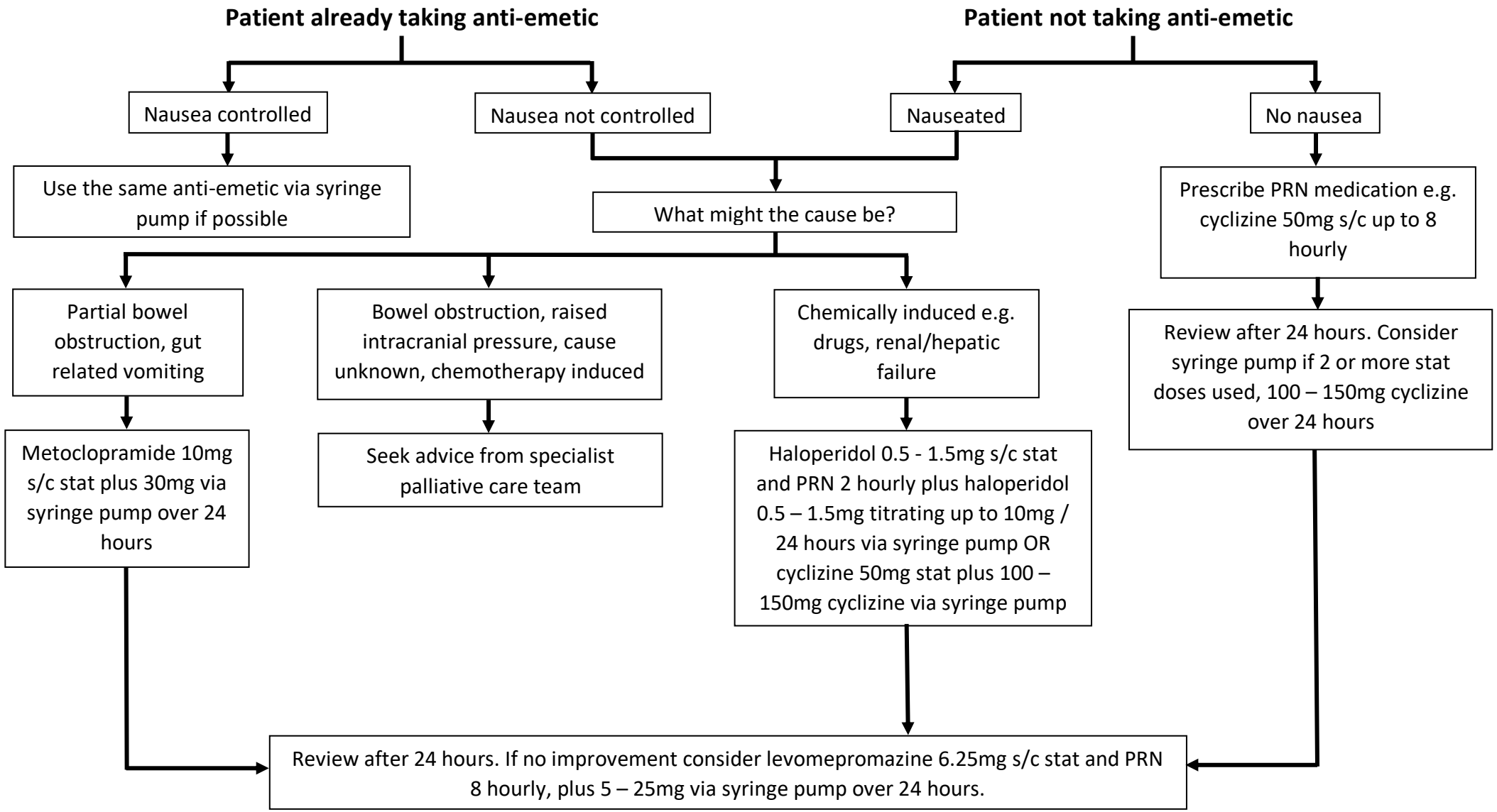
Nausea and Vomiting



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Anxiety, Delirium and Terminal Agitation

Treat reversible causes e.g. pain, urinary retention

Anxiety

Benzodiazepines should be used 1st line for agitation with no signs of delirium.

Delirium

Haloperidol should be used 1st line for delirium.

Caution with haloperidol in Parkinson's.

Terminal Agitation

Midazolam 2.5mg - 5mg s/c stat plus PRN up to every TWO hours.

Maximum 6 doses in 24 hours.

If 2 or more doses required in 24 hours start s/c syringe pump with 10mg - 20mg midazolam over 24 hours.

Continue to give PRN doses as needed and review daily.

If patient not settled on midazolam 10mg via syringe pump, titrate midazolam up gradually (e.g. to 15mg or 20mg, then potentially to 30mg if symptoms persist).

If agitation persists despite 30mg of midazolam in 24 hours, consider adding levomepromazine 12.5mg – 25mg or haloperidol 3mg – 5mg before increasing midazolam above 30mg/24h.

Levomepromazine and haloperidol may be added earlier at clinical discretion, if felt to be of particular benefit (e.g. patient has marked delirious features).

If not settled, seek help from specialist palliative care team.

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Version	1
Developed by	Pharmacy and Medicines Optimisation Team, Hertfordshire and West Essex (HWE) ICB with relevant HWE ICS stakeholders.
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Date approved / updated	June 2024
Review Date	This HWE APC recommendation is based upon the evidence available at the time of publication. This recommendation will be reviewed upon request in the light of new evidence becoming available.
Superseded versions	West Essex Primary Care medication guidelines for anticipatory last days of life, approved by MOPB December 2018. Hertfordshire End of Life Care Anticipatory Prescribing Guidance v3, approved by HWE APC November 2023.