

Symptom control in the last days of life

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team. Version 5

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Principles of symptom management in last days of life

These principles are applicable to the care of patients who may be dying from any cause

Recognise that death is approaching

Studies have found that dying patients will manifest some or all of the following:

- Profound weakness usually bedbound
- Drowsy or reduced cognition semi-comatose
- Diminished intake of food and fluids only able to take sips of fluid
- Difficulty in swallowing medication no longer able to take tablets

Treatment of symptoms

The prime aim of all treatment at this stage is the control of symptoms current and potential.

- Discontinue any medication which is not essential
- Prescribe medication necessary to control current distressing symptoms
- All patients who may be dying would benefit from having ANTICIPATORY subcutaneous medication prescribed JUST IN CASE distressing symptoms develop
- All medication needs should be reviewed every 24 hours
- Prn medications may be administered via a Saf -T- intima line
- If two or more doses of prn medication have been required, then consider the use of a syringe driver for continuous subcutaneous infusion (CSCI)

The most frequently reported symptoms are:-

- Pain
- Nausea / Vomiting
- Excessive secretions / Noisy breathing
- Agitation / Restlessness
- Dyspnoea

Opioid choice and syringe drivers

Morphine sulphate is the injectable opioid of choice in the majority of patients.

Alternative opioids (when morphine is not tolerated or in patients with severe rena

Alternative opioids (when morphine is not tolerated or in patients with severe renal failure e.g. GFR < 30mL /min) include oxycodone or alfentanil.

Both morphine sulphate and oxycodone are compatible with all the medications that are recommended in the following guidelines (cyclizine, haloperidol, levomepromazine, hyoscine butylbromide, glycopyrronium, metoclopramide, ondansetron and midazolam).

Incompatibility may occur when higher doses of oxycodone >150mg are mixed with cyclizine. Alfentanil is compatible with all the above medications that are recommended, with exception of cyclizine.

Use either water for injection or sodium chloride 0.9~% as the diluent, **unless mixing with cyclizine**, when water for injection must be used.

Use sodium chloride 0.9 % for levomepromazine by itself or syringe driver combinations containing octreotide, methadone, ketorolac, ketamine or furosemide

T34 McKinley syringe drivers use a 20mL syringe as standard and if a larger volume is required use a 30mL syringe.

For information on the usual doses of drugs used in a syringe driver see inside of back cover.

For guidance on converting between opioids see the coloured opioid conversion chart.

For further information on compatibility in a syringe driver contact:

York and Scarborough Hospital enquiries York Medicines Information	GP enquiries Newcastle Medicines Information
01904 725960	0191 2824631

Mouth care guidelines

General principles of mouth care

Assess the whole mouth daily

Clean the teeth and tongue using a toothbrush and toothpaste, morning and night. *If patients have apthous ulcers avoid toothpastes containing sodium laural sulphate* Ensure all toothpaste is rinsed away.

Offer mouth care every 3 to 4 hours using a soft toothbrush.

Use lip salve for dry lips. Care when using oxygen mask.

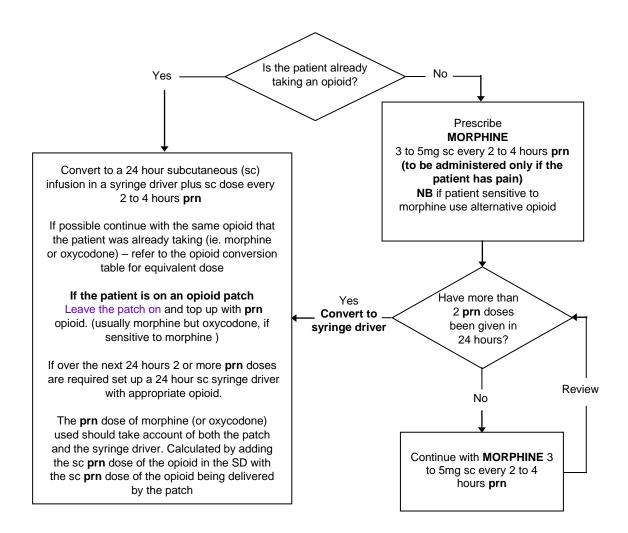
Note any history of pain, dry mouth, change of taste, medications and respond if required.

Document findings

Problem	Action				
Dry mouth	Consider discontinuing contributing factors, e.g. medication. If required, consider humidifying oxygen. Implement general mouth care principles. Offer fluids hourly if appropriate. Consider topical saliva substitutes, e.g. Oralieve				
Coated tongue	Implement general mouth care principles. Rinse the mouth after food with water. Encourage fluids as appropriate.				
	If no improvement in 24 hours consider infection as a cause.				
Pain / mucositis / ulceration	Implement general mouth care principles. Consider analgesia – topical/systemic. Use soft toothbrush for hygiene. Consider diluting mouthwash if the patient finds their use painful.				
	Seek specialist advice if symptoms continue.				
Infection	Rinse mouth 3 times per day with chlorhexidine 0.2% (Corsodyl) or sodium chloride 0.9%. Implement general mouth care principles. Check for thrush and treat with antifungal, if appropriate. e.g. nystatin, fluconazole or miconazole				

Pain Control

(Non renal pathway – see next page for patients with renal failure)



Remember:

Any change in the syringe driver dose should take account of the number of **sc prn doses** given over the last 24 hours. If you change the syringe driver 24 hour dose remember to change the 4 hourly **prn** dose as well.

To calculate the prn dose of sc morphine

Prescribe 1/6th of the 24 hour dose in the driver e.g 20mg sc via driver over 24 hours will require 3 to 5mg sc every 4 hours **prn**

- Use the opioid conversion chart on the back of this booklet to help in converting between opioids
- If in doubt please seek advice from the palliative care team
- It is good practice to document calculations in notes and check dose conversions with a colleague.
- Patients on opioid patches if a patient requires a syringe driver the opioid patch should continue to be prescribed. The syringe driver (SD) used as a top up and titrated as necessary if, pain is opioid sensitive, Do not increase total opioid dose by >30 to 50%.
- The prn dose of opioid should be calculated by adding the prn sc dose of opioid in the syringe driver with the prn sc equivalent given by patch

Pain control in renal failure Patients with severe renal failure i.e. eGFR < 30mL/min use oxycodone. If eGFR <15mL/min use Alfentanil in the SD but only use prn Alfentanil if patient unable to tolerate oxycodone Is the patient already No. Yes taking an opioid? If eGFR >/= 15mL/min Prescribe OXYCODONE If patient is already taking and tolerating oral 1 to 2mg sc every 2 to 4 hours **prn** if the patient has pain **OXYCODONE** and GFR >/= 15mL/min convert to 24 hour sc syringe driver plus sc dose every 2 to If eGFR <15mL/min 4 hours **prn** Prescribe OXYCODONE prn if tolerates BUT if unable to tolerate oxycodone If unable to tolerate oxycodone or eGFR <15 Prescribe ALFENTANIL 250micrograms sc every 2 to Convert to ALFENTANIL sc syringe driver over 24 hour using opioid conversion table. 4 hours prn if the patient has pain Prescribe sc opioid every 2 to 4 hours prn (up to a maximum of 6 prn doses in 24 hours) (Although alfentanil sc may be prescribed prn alongside the syringe driver it has a very short duration of action so oxycodone is used instead, Have more than 2 Yes if patient can tolerate this. prn doses been Convert to Take EXTRA care when calculating and given in 24 syringe driver amending doses for syringe driver and prn use if hours? the drugs are different. If the patient is on an opioid patch Review Leave the patch on and top up with prn No oxycodone or alfentanil (if oxycodone intolerant) If over the next 24 hours 2 or more prn doses are required set up a 24 hour sc syringe driver with

Remember:

Continue with OXYCODONE or

ALFENTANIL as initiated above

Any change in the syringe driver dose should take account of the number of **sc prn doses** given over the last 24 hours. If syringe driver opioid dose is changed remember to change the **prn** dose **To calculate the prn dose of oxycodone or alfentanil**

For **prn** dose prescribe 1/6th of the 24 hour syringe driver dose e.g 3mg alfentanil sc via driver over 24 hours will require 3mg oxycodone sc every 2 to 4 hours **prn_OR** 500 microgram alfentanil sc **prn** every 2 to 4 hours (up to a maximum of 6 prn dose in 24 hours) e.g. 20mg oxycodone sc via driver over 24 hours will require 3mg oxycodone sc **prn** every 2 to 4 hours NB If the patient is also on a patch you must calculate how much **prn** sc oxycodone or alfentanil this is equivalent to and add to **prn** dose of SD)

- Use the opioid conversion chart on the back of this booklet to help in converting between opioids
- If in doubt please seek advice from the palliative care team

oxycodone or alfentanil determined by eGFR.

The **prn** dose of opioid used should take account

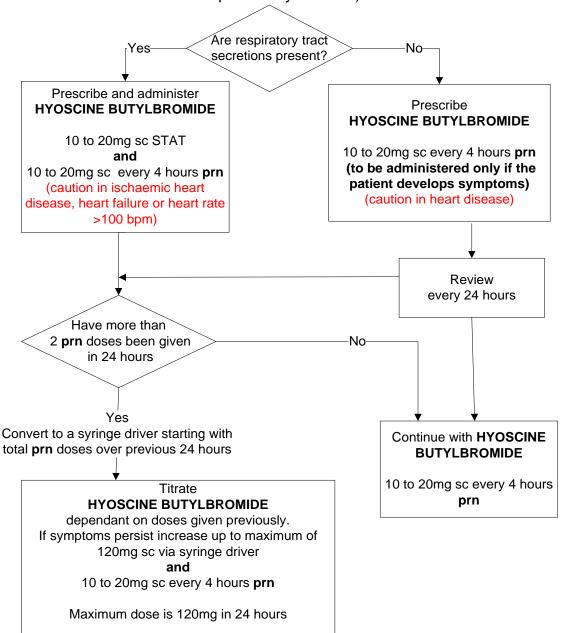
of both the patch and the syringe driver

- It is good to document calculations in notes and check dose conversions with a colleague.
- Patients on opioid patches if a patient requires a syringe driver the opioid patch should continue to be prescribed at the usual dose and the syringe driver used as a top up and titrated as necessary. The prn dose of opioid should be calculated by adding the prn sc dose of opioid in the syringe driver with the prn sc equivalent given by patch

Respiratory tract secretions

(Remember you cannot clear existing secretions, but you can help stop further production)

These drugs only reduce upper airways secretions and not lower collections from e.g. infectionor pulmonary oedema)



HYOSCINE BUTYLBROMIDE (BUSCOPAN) above 60mg in 24 hours may precipitate when mixed with CYCLIZINE. If problems discontinue cyclizine and switch to levomepromazine. Caution in heart disease

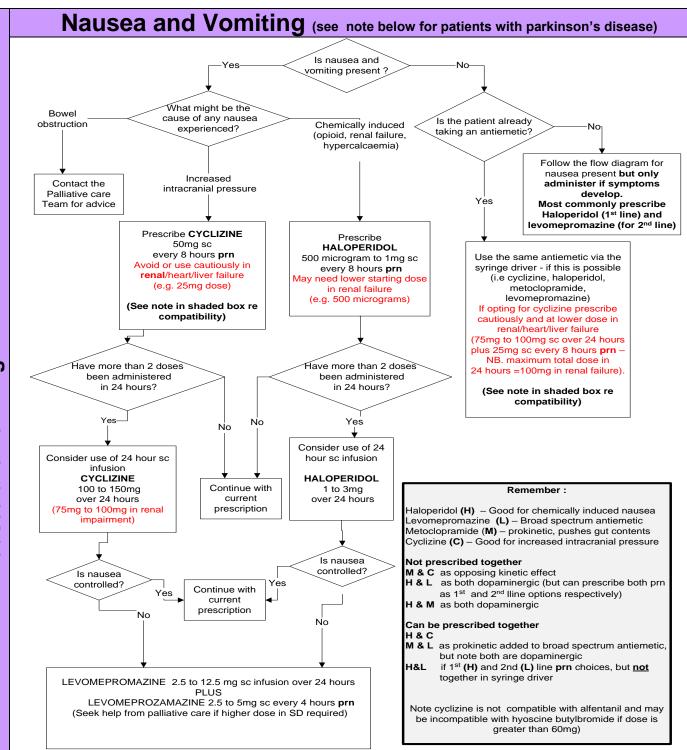
GLYCOPYRRONIUM may be used as an alternative if hyoscine butylbromide not effective (reduced doses in renal failure).

HYOSCINE HYDROBROMIDE is **not recommended in patients with renal failure** because of excessive drowsiness or paradoxical agitation.

Agitation / Terminal restlessness Before prescribing have all reversible causes been excluded? e.g. urinary retention Is agitation/ terminal Yes No restlessness present? Prescribe **MIDAZOLAM** Prescribe and adminster **MIDAZOLAM** 2 to 5mg sc every 2 to 4 hours prn 2 to 5mg sc every 2 to 4 hours prn (to be administered only if the patient develops symptoms) Review every 24 hours Have more than 2 prn doses been given in 24 hours? Calculate amount of MIDAZOLAM administered Yes over the last 24 hours and set up a Convert to a syringe driver with this dose syringe driver and 2 to 5mg sc every 2 to 4 hours prn No Continue with Is the patient's **MIDAZOLAM** agitation controlled? 2 to 5mg sc every 2 to 4 hours prn Yes No Increase dose of MIDAZOLAM in syringe driver to maximum of 60mg Review (30mg in renal failure) in 24 hours every 24 hours and Continue with 2 to 5mg sc every 2 to 4 hours prn current prescription Maximum dose in 24 hours is 60mg (NB 30mg in renal failure) which includes both prn doses and syringe driver

NB if uncontrolled on a maximum of 60mg midazolam (30mg in renal failure) consider levomepromazine starting at 6.25mg prn. Further doses may need to be added to the syringe driver. If symptoms continue contact the Specialist Palliative Care Team.

Seek advice if more required



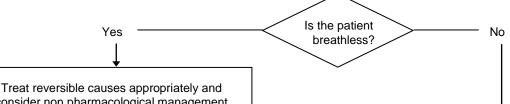
Patients with Parkinson's disease - the above choices are best avoided - 5HT3 receptor-antagonist are preferred (eg ondansetron – see syringe driver chart and if unsure seek advice from palliative care). Avoid if possible all dopamine antagonists (e.g haloperidol and levomepromazine)

Please consult the top of page 2 of the Anticipatory drug and syringe driver for maximum doses of antiemetics

Dyspnoea (Breathlessness)

(Non renal pathway —see next page for patients with renal failure)

Opioids are more useful for patients who are breathless at rest than those who are breathless on exertion - PCF7.



No

consider non pharmacological management such as positioning, cool air, reassurance

Is the patient already taking an opioid (oral or patch)?

Use prn doses for breathlessness even if not in pain

Opioid doses required to relieve breathlessness may be less than the **prn** dose used for pain **Look at the footnote**

Convert to **MORPHINE** (or alternative opioid)
24 hours sc infusion using the opioid conversion table
plus sc prn doses

If the patient is on an opioid patch

Leave the patch on and initially top up with **prn** morphine or alternative opioid. See footnote

If over the next 24 hours 2 or more **prn** doses are required set up a 24 hour sc syringe driver with appropriate opioid

The **prn** dose of morphine (or alternative opioid) used for breathlessness may be much less than the dose used for pain. **See footnote**

If concurrent anxiety

Consider also prescribing MIDAZOLAM 2mg sc every 2 to 4 hours prn

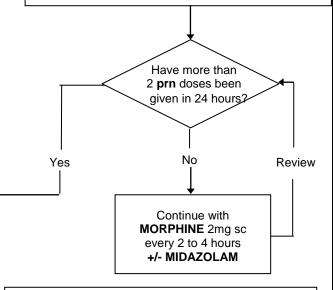
If more than 2 **prn** doses required in 24 hours put total dose given in 24 hours into syringe driver Maximum **MIDAZOLAM** dose 30mg in 24 hours

If symptoms continue contact the specialist palliative care team

Prescribe MORPHINE 2mg sc every 2 to 4 hours prn (to be administered only if the patient develops breathlessness)

(If concurrent anxiety consider also prescribing MIDAZOLAM 2mg sc every 2 to 4 hours prn)

NB if patient sensitive to morphine use alternative – but note lack of evidence for other opioids



To calculate the prn dose of morphine or alternative opioid

Look at the footnote
Severe breathlessness
50% analgesic dose is 1/12th of the 24 hours dose
Moderate breathlessness
25% analgesic is the 1/24 of the 24 hour dose
Mild breathlessness
25% analgesic dose is 1/24 of the 24 hours dose

Note:

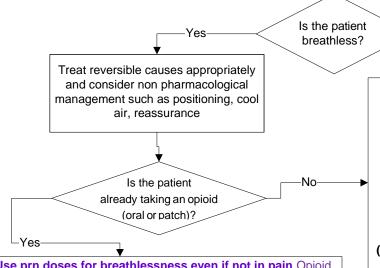
Severe breathlessness Verbal rating score >7/10 a dose that is 50% of 4 hourly analgesic dose may be needed Moderate breathlessness Verbal rating score 4 to 6/10 a dose that is 25 to 50%% of 4 hourly analgesic dose may be needed

Mild breathlessness Verbal rating score <3/10 a dose that is 25% of 4 hourly analgesic dose may be needed Morphine is normally used for breathlessness. This is the opioid which has the best evidence base for treatment of breathlessness. In renal impairment however morphine accumulates and alfentanil or oxycodone is preferred for this reason

Dyspnoea (Breathlessness) in Renal Failure

(Patients with severe renal failure i.e. GFR < 30mL/m use oxycodone or <15mL/min use Alfentanil if unable to tolerate oxycodone)

Opioids are more useful for patients who are breathless at rest than those who are breathless on exertion PCF7.



Use prn doses for breathlessness even if not in pain Opioid doses required to relieve breathlessness may be less than the **prn**

dose used for pain. See footnote

If patient is already taking and tolerating oral **OXYCODONE** and GFR >15mL/min convert to **OXYCODONE** 24 hour sc syringe driver <u>plus</u> sc dose ever 2 to 4 hours **prn**

If eGFR <15mL/min or unable to tolerate Oxycodone

Convert to ALFENTANIL SD

24 hour sc infusion using the opioid conversion table $\underline{\textbf{plus}}$ sc dose every 2 to 4 hours $\underline{\textbf{prn}}$ (up to a maximum of 6 $\underline{\textbf{prn}}$ doses in 24 hours)

(Note oxycodone, if tolerated, may be used as the **prn** opioid – see pain flow chart in renal patients).

If the patient is on a opioid patch

Leave the patch on and initially top up with **prn** oxycodone or alfentanil (if oxycodone not tolerated).

If over the next 24 hours 2 or more **prn** doses are required set up a 24 hour sc syringe driver with oxycodone or alfentanil

The **prn** dose of oxycodone or alfentanil used should take account of both the patch and the syringe driver

If concurrent anxiety

Consider also prescribing MIDAZOLAM 2mg sc every 2 to 4 hours prn.

If more than 2 **prn** doses required in 24 hours put total dose given in 24 hours into syringe driver Maximum **MIDAZOLAM** dose 30mg in 24 hours

If symptoms continue contact the specialist palliative care team

If eGFR >/= 15mL/min Prescribe OXYCODONE

1 to 2mg sc **prn** every 2 to 4 hours if patient develops breathlessness

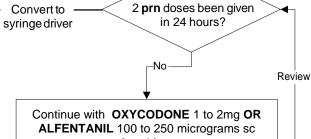
If eGFR <15mL/min

Prescribe **OXYCODONE prn** if tolerates **BUT if unable to tolerate oxycodone**

Prescribe **ALFENTANIL** 250micrograms sc every 2 to 4 hours **prn** for breathlessness

(If concurrent anxiety consider also prescribing MIDAZOLAM 2 mg sc every 2 to 4 hours prn)

Yes



Have more than

ALFENTANIL 100 to 250 micrograms sc every 2 to 4 hours prn (up to a maximum of 6 prn doses in 24 hours) +/- MIDAZOLAM

To calculate the prn dose of opioid for breathlessness

Look at the foot note

Severe breathlessness

50% analgesic dose is 1/12th of the 24 hour dose Moderate breathlessness

25% analogesic is the 1/24 of the 24 hour dose Mild breathlessness

25% analgesic dose is 1/24 of the 24 hour dose

Note:

Severe breathlessness Verbal rating score >7/10 a dose that is 50% of 4 hourly analgesic dose may be needed Moderate breathlessness Verbal rating score 4 to 6/10 a dose that is 25 to 50%% of 4 hourly analgesic dose may be needed Mild breathlessness Verbal rating score <3/10 a dose that is 25% of 4 hourly analgesic dose may be needed

Morphine is normally used for breathlessness. This is the opioid which has the best evidence base for treatment of breathlessness. In renal impairment however morphine accumulates and alfentanil or oxycodone is preferred for this reason

Last days of life Diabetes Care Management Algorithm

York and Scarborough Teaching Hospitals NHS Foundation Trust

Discuss changing the approach to diabetes management with patient and/or family if not already explored. If the patient remains on insulin, ensure the diabetes specialist nurses are involved and agree with the monitoring strategy.

Type 1 diabetes Type 2 diabetes on other tablets Type 2 diabetes always on insulin and/or insulin or glucagon-like controlled with peptide-1 (GLP-1) agonist 1 diet or metformin If patient on twice daily Continue on Stop tablets and GLP-1 mixed insulin: current Stop monitoring injections. Consider stopping background blood glucose • Either prescribe once insulin if insulin requirement (long acting) daily morning dose of ≤10 units insulin or Isophane insulin 3 usual insulin if pt requests Long acting insulin this with glargine (Lantus) If insulin stopped: If insulin to continue: reduction in Check capillary blood Either prescribe once dose by 25% (Based on daily morning dose of glucose (CBG) once a 25% less than total isophane insulin day at teatime daily insulin dose) • If CBG over 20mmol/L give 4 units of short Long acting insulin acting insulin 2 glargine (Lantus) Re check CBG after 2 Check capillary blood glucose (Based on 25% less hours once a day at teatime: than total previous daily insulin dose) If <8mmol/I reduce insulin by If patient requires short 10 to 20% acting insulin 2 more than If >20mmol/l Increase insulin twice, consider daily by 10 to 20% to reduce risk isophane insulin 3 or of symptoms or ketosis insulin glargine (Lantus)

KEY

- Byetta (Exenatide)
 Victoza, (Liraglutide)
 Lyxumia (Lixisenatide)
 Trulicity (Dulaglutide)
 Bydureon (Exenatide prolonged release)
- 2 Novorapid
 Apidra
 Humalog
 Onset 5 to 15 mins
 Peak 1 to 2 hours
 Duration 3 to 5 hours
 Onset 30 to 45 mins
 Actrapid
 Peak 2 to 4 hours
- 3 Insulatard Onset 2 hours Humulin I Peak 4 to 8 hours

- Keep tests to a minimum. It may be necessary to perform some tests to ensure unpleasant symptoms do not occur due to low or high blood glucose.
- It is difficult to identify symptoms due to hypoglycaemia or hyperglycaemia in a dying patient.
- If symptoms are observed, it could be due to abnormal blood glucose levels.
- Test urine or blood for glucose if the patient is symptomatic.
- Observe for symptoms in previously insulin-treated patients where insulin has been discontinued.
- Insulin 2 & 3 in Key are in order of preference for use in patients in last days of life.

For queries relating to the diabetes flowchart please contact York Hospital Support 01904 726091 York Community Support 01904 724938 and in Scarborough 01723 342274

For queries relating to palliative care please contact the Palliative Care Team

For more information see
Best Practice Guidelines
on Staff Room

Adapted from End of Life Diabetes care: Clinical care recommendations 2nd edition
Author: Think Glucose and Anne Garry, Palliative Care. Owner: Think Glucose. Version 4
Date for review October 2024

Duration 6 to 8 hours

Guidance for prescribing anticipatory medicines subcutaneously

If your patient has renal failure look at the cautions in red

Drug	Use	Stat dose sc	24 hours sc dose in syringe driver (SD)	Usual max dose in 24 hours (prn + SD)					
	Medication for nausea and vomiting								
CYCLIZINE 50mg in 1mL	Centrally acting on vomiting centre. Good for nausea associated with bowel obstruction or increased intracranial pressure Dilute with water Note Dose reduction may be necessary in renal, cardiac or liver failure e.g. 25mg	50mg (25mg in patients with renal/heart/ liver failure.) Do not use if patient has two or more of above risk factors	100 to 150mg (75 to 100mg in renal/heart/liver failure)	150mg (75 to 100mg in renal/heart/liver failure)					
HALOPERIDOL 5mg in 1mL	Good for chemically induced nausea	500microgram to 1mg May need lower dose in elderly/renal failure 500microgram	1 to 3mg	5mg					
METOCLOPRAMIDE 10mg in 2mL NB MHRA caution	Antiemetic action 1. Prokinetic (accelerates GI transit) 2. Centrally acting on chemoreceptor trigger zone (CTZ), blocking transmission to vomiting centre	10mg (5 to 10mg)	30 to 60mg (30mg in renal failure)	100mg (30mg in renal failure)					
LEVOMEPROMAZINE 25mg in 1mL	Broad spectrum antiemetic, works on chemo-receptor trigger zone (CTZ) and vomiting centre (at lower doses) Dilute with sodium chloride 0.9% when used alone	2.5 to 5mg	2.5 to 12.5mg	12.5mg If require higher doses consult palliative care					
	Medication fo	r agitation							
MIDAZOLAM 10mg in 2mL	agitation). Also anticonvaisant and		5 to 60mg (30mg in renal failure) Start with lower dose & titrate	60mg (30mg in renal failure)					
LEVOMEPROMAZINE 25mg in 1mL	Antipsychotic used for terminal agitation (2 nd line to midazolam)	5 to 12.5mg Start with lower dose & titrate	5 to 50mg Seek help with higher doses	200mg (25mg to 50mg in renal failure)					
	Medication for respin	ratory secretic	ns						
HYOSCINE BUTYLBROMIDE 20mg in 1mL	LBROMIDE May precipitate when mixed with		10 to 20mg Caution in heart disease 40 to 120mg						
GLYCOPYRRONIUM 200microgram in 1mL	Antisecretory - useful in reducing respiratory tract secretions Also has antispasmodic properties	200microgram (100microgram)	400 to1200 microgram (1.2mg) (200 to 600 microgram)	1200 micrograms (1.2mg) (600 microgram in renal failure)					

Opioid dose conversion chart, syringe driver doses, rescue / prn doses and opioid patches

Use the conversion chart to work out the equivalent doses of different opioid drugs by different routes. The formula to work out the dose is under each drug name. Examples are given as a guide

Oral opioid mg /24 hour (Divide 24 hour dose by six for 4 hourly prn oral dose) Subcutaneous infusion of opioid Syringe driver (SD) dose in mg per 24 hours (or micrograms for alfentanil where stated)		Subcutaneous prn opioid Dose in mg every 4 hours injected as required prn NB Alfentanil in lower doses in micrograms			Opioid by patch Dose microgram/hour						
Morphine 24 hour	Oxycodone 24 hour	Diamorphine sc 24 hour	Morphine sc 24 hour	Oxycodone sc 24 hour	Alfentanil sc 24 hour (500microgram/mL)	Diamorphine 4 hour	Morphine 4 hour	Oxycodone 4 hour	Alfentanil 2 to 4 hour (500microgram/ mL)	Fentanyl normally change every 72 hours	Buprenorphine B=Butec change every 7 days T = Transtec change 96 hrs (4 days)
	Calculated by	Calculated by	Calculated by	Calculated by	Calculated by	Prn dose is one sixth (1/6 th) of 24 hour subcutaneous (sc)				Conversions use UK SPC	
	dividing 24 hour oral morphine	dividing oral morphine	dividing oral morphine	dividing oral oxycodone	dividing 24 hour oral morphine	syringe driver dose plus opioid patches if in situ. NB Alfentanil injection is short acting. Maximum 6 prn					
	dose by 2	dose by 3	dose by 2	dose by 2	dose by 30	doses in 24 hours. If require more seek help					
20	10	5	10	5	500mcg	1	2	1	100mcg	(6)	B 10
45	20	15	20	10	1500mcg	2	3	2	250mcg	12	B 20
90	45	30	45	20	3mg	5	7	3	500mcg	25	T 35
140	70	45	70	35	4500mcg	8	10	5	750mcg	37	T 52.5
180	90	60	90	45	6mg	10	15	8	1mg	50	T 70
230	115	75	115	60	7500mcg	12	20	10	1.25mg	62	T 70 + 35
270	140	90	140	70	9mg	15	25	10	1.5mg	75	T70 + 52.5
360	180	120	180	90	12mg	20	30	15	2mg	100	T 140
450	225	150	225	110	15mg	25	35	20	2.5mg	125	-
540	270	180	270	135	18mg	30	45	20	3mg	150	-
630	315	210	315	160	21mg	35	50	25	3.5mg	175	-
720	360	240	360	180	24mg	40	60	30	4mg	200	-

Equivalent doses if converting from oral to sc opioid

Calculation of breakthrough/ rescue / prn doses

Oral prn doses:

Morphine or Oxycodone: 1/6th of 24 hour oral dose

Subcutaneous:

- Morphine & Oxycodone: 1/6th of 24 hour sc syringe driver (SD) dose
- Alfentanil: 1/6th of 24 hour sc SD dose
 - o Short action of up to 2 hours
 - Seek help If reach maximum of 6 prn doses in 24 hours

(For ease of administration, opioid doses over 10mg, prescribe to nearest 5mg)

Renal failure/impairment GFR<30mL/min: Morphine/Diamorphine metabolites accumulate and should be avoided.

- Fentanyl patch if pain is stable.
- Oxycodone orally or by infusion if mild renal impairment
- If patient is dying & on a fentanyl or buprenorphine patch top up with appropriate sc oxycodone or alfentanil dose & if necessary, add into syringe driver as per renal guidance
- If GFR<15mL/min and unable to tolerate oxycodone use alfentanil sc

If unsure please seek help from palliative care

Fentanyl and buprenorphine patches in the dying/moribund patient

- Continue fentanyl and buprenorphine patches in these patients.
 - o Remember to change the patch(es) as occasionally this is forgotten!
 - o Fentanyl patches are more potent than you may think

If pain occurs whilst patch in situ

- Prescribe 4 hourly prn doses of subcutaneous (sc) morphine unless contraindicated.
- Use an alternative sc opioid e.g. alfentanil or oxycodone in patients with
 - o poor renal function,
 - o morphine intolerance
 - where morphine is contraindicated
- Consult pink table when prescribing 4 hourly prn subcutaneous opioids Adding a syringe driver (SD) to a fentanyl or buprenorphine patch

If 2 or more rescue/ prn doses are needed in 24 hours, start a syringe driver with appropriate opioid and continue patch(es). The opioid dose in the SD should equal the total prn doses given in the previous 24 hours up to a maximum of 50% of the existing regular opioid dose. Providing the pain is opioid sensitive continue to give prn sc opioid dose and review SD dose daily.

E.g. Patient on 50 micrograms/hour fentanyl patch, unable to take prn oral opioid and in last days of life. Keep patch on. **Use appropriate opioid for situation or care setting.** If 2 extra doses of 15 mg sc morphine are required over the previous 24 hours, the initial syringe driver prescription will be morphine 30mg/24 hour. **Remember** to look at the **dose of the patch and the dose in the syringe driver** to work out the **new** opioid breakthrough dose **each time a change is made**.

Always use the chart above to help calculate the correct doses.