Symptom Management Guidelines for Dying Patients (Adults)

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Distribution:	**Trust-wide (except Paediatrics)**		
Location:	Trust Intranet: Clinical Policies, Procedures & Guidance		
This document should be read in conjunction with:	Care Agreement for the Last Hours and Days of Life (Cerner Document) Guidelines for the Care and Management of a Patient with a CME Medical T34 Syringe Pump for Adult Palliative Care Patients – May 2026 Trust Guide to the Intravenous Administration of Medicines (Adult) – Dec 2025 Trust Medicines Policy – Section: 6. Controlled Drugs – Nov 2025 Trust Medicines Policy – Section: 17. Injectable Medicines Policy – July 2026 Trust Medicines Policy Section 31. Medicines Management Training – March 2027		
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Stakeholders involved:	Clinicians in all adult in-patient areas, Specialist Palliative Care Team & Pharmacy		
Applicable to:	Trust-wide		
Directorate responsible for the document:	Medicine		
Pharmacy approval:	Maggie Bendle, Lead Clinical Pharmacist - Cancer and Technical Services, 03/05/2023		

Document review history:

Date	Version	Responsibility	Comments
Jul 2013	1	Dr Sarah Cox, Gary Artiss, Natasha Ryan-Davies	
Aug 2015	2	Dr Sarah Cox, Gary Artiss, Karen Simpson, Natasha Ryan-Davies, Joel Mcilveen	
Apr 2017	3	Dr Sarah Cox, Dr Kausar-Sohaib, Karen Simpson	
Mar 2018	4	Dr Sarah Cox, Dr Kausar-Sohaib, Dr Ruth Caulkin	Updated guidance for patients with renal and liver impairment.
Aug 2019	5	Dr Ruth Caulkin, Shauna McCann, Natasha Ryan-Davies	Anticipatory prescribing when discharging patients home added.
May 2021	6	Dr Ruth Caulkin, Dr Antonia Field-Smith, Sarah MacDonald, Maggie Bendle	Cerner prescribing advice, individualised care planning, COVID-19 symptom control added. Discharging patients with anticipatory medications advice updated.
Jun 2023	7	Dr Ruth Caulkin, Dr Louise Robinson, Shauna McCann	Guideline updated.

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Scope of the Guidelines

These guidelines are for all trained staff involved in the administration of medications intended for use to treat symptoms when the patient is:

In the last hours or days of life and/or unable to take oral medications.

The administration of medications intended for use to treat symptoms in all palliative care patients is beyond the scope of this guideline.

A standalone short Symptom Control Guide for Patients with COVID-19 can be seen in **Appendix A**.

Contact Details for the Specialist Palliative Care (SPC) Team

The Specialist Palliative Care (SPC) team can give symptom control advice for patients at the end of life. The team can also support the patient's usual medical or surgical team in having conversations with families and carers in a shared-care model.

The quickest way to refer your patient to the team is to use the referral order on Cerner:

- From the Orders tab – add an order, search 'refer to' and select 'Specialist Palliative Care Team'.
- The order form guides you through giving the essential information and logs the referral in the patient's record.

Chelsea and Westminster Hospital

If urgent or at the weekend, in addition to completing the Cerner referral, please **bleep 4026.**

Additional Contact Numbers: Ext: 58499
Palliative Medicine SPR – bleep 0175
FY2 – bleep 0181
Pharmacist - Bleep 0180

Face to face service available: Monday to Friday 9am – 5pm
Saturday/Sunday/Bank Holidays 8am – 4pm

Occasionally due to staffing resources there may be a reduced weekend service- check with site management team.

Out of Hours (5pm – 9am)**:** On call StR telephone advice at Trinity Hospice 020 7787 1000

West Middlesex Hospital

If urgent or at the weekend, in addition to completing the Cerner referral, please **bleep 018**.

Additional Contact Numbers: Ext: 6822
Pharmacist - Bleep 116

Face to face service available: Monday to Friday 9am – 5pm
Saturday/Sunday/Bank Holidays 8am – 4pm

Occasionally due to staffing resources there may be a reduced weekend service- check with site management team.

Out of Hours**:** On call medical telephone advice at Meadow House Hospice 0208 967 5597

Background

Patients nearing the end of their life require individualised care for themselves and those who are important to them, that prioritises comfort and dignity and is in line with their expressed wishes.

Healthcare staff have a duty and responsibility to achieve the following five priorities when involved with the care of a dying person:

1. Recognise
The possibility that a person may die within the next few days or hours is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.
Always consider reversible causes, e.g. infection, dehydration, hypercalcaemia, etc

2. Communicate
Sensitive communication takes place between staff and the dying person, and those identified as important to them.

3. Involve
The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.

4. Support
The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.

5. Plan & Do
An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

Leadership Alliance for the Care of Dying People (2014)

Individualised Care Plan

All dying patients should have an individualised care plan documented on Cerner which should consider the following:

- Stopping observations – unless they alter management
- Hydration and nutrition – some patients may require IV or SC fluids if symptomatic of dehydration and unable to maintain oral intake
- Regular mouthcare – continuous oxygen and medications can cause dry mouth and nasal passages
- Oxygen requirement – consider weaning oxygen gradually and/or switching to nasal cannula once the patient is comfortable
- Family members – ensure they are regularly updated and involved
- Spiritual and cultural needs – offer chaplaincy support.

To document this **consultant-led decision**, the Trust uses an electronic form in Cerner entitled:

'Care Agreement for the Last Hours and Days of Life'.

Short help guides on how to use the Care Agreement, and the supporting 'Daily Review' and 'Nursing Care Plan', can be found on the Cerner EPR intranet page or follow links below.

How to use care agreement for last hours and days of life
http://connect.chelwest.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=142146

Daily review of care agreement for last hours and days of life
http://connect.chelwest.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=142146

Ordering and completing the nursing care plan for last hours and days of life
http://connect.chelwest.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=140687

Additional advice or local training on the above can be discussed with the SPC Team.

Prescribing Advice

Guidance on symptoms associated with the dying patient and their pharmacological management can be found in the algorithms on the following pages.

Anticipatory Symptom Control at End of Life PRN Medication Prescribing on Cerner

The prescriptions for these can be added through the 'Medications' tab in Cerner. Search the phrase 'antic' and an order set with four commonly used medications entitled 'Anticipatory Medications at End of Life' can be found. Within this order set, select the appropriate medications and doses based on the most recent known renal function.

Continuous Subcutaneous Syringe Pump Prescribing on Cerner

The prescription is written as an 'Order' in Cerner using 'Continuous Subcutaneous Syringe Pump' order set with medications as additives – see **Appendix B** for prescribing advice.

Select the first option: '17ml syringe pump' – unless total volume of drugs exceeds this, in which case select 22ml or 32 ml. Higher doses of multiple medications in combination may cause larger volumes to be needed for the syringe – check the ward stock of the required medications and their concentrations and discuss with pharmacy and/or the SPC Team if further advice needed.

Review syringe pump prescription **daily** and consider adjusting doses following patient review if symptoms not controlled. Advice can be sought from the SPC Team.

Crisis Medication Prescribing

In the event of risk of catastrophic haemorrhage or prolonged seizure activity, additional advice should be sought from the SPC Team regarding crisis pack medications.

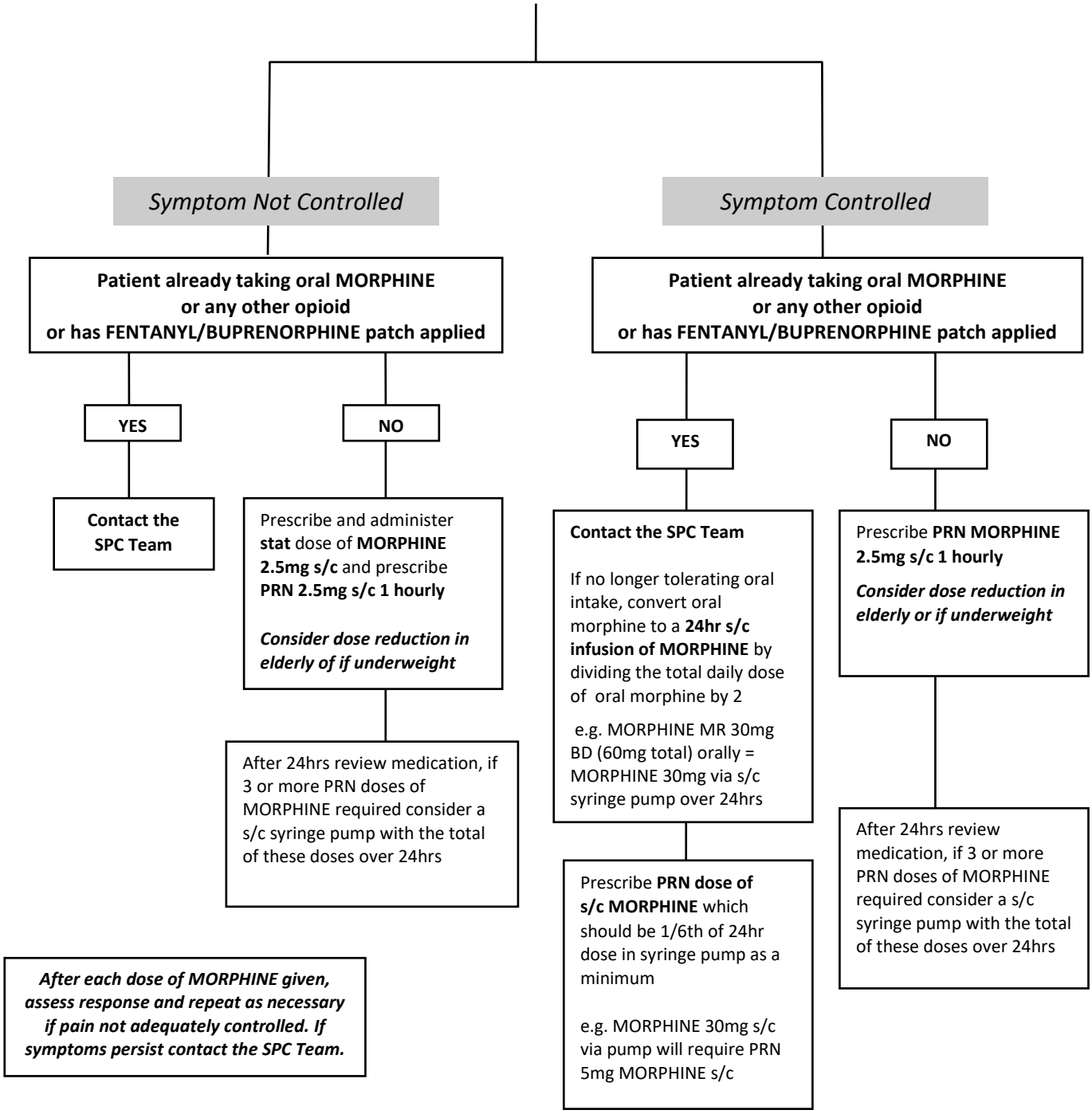
Anticipatory Medication Prescribing on Discharge for Patients in the Last Days of Life (Home or Nursing Home)

Please contact the SPC team to discuss further – specialist discharge advice may be needed.
See **Appendix C** for further prescribing and dispensing guidance.

- Please refer to the prescribing guidelines below for medications and doses.
- Ensure that the TTAs are prescribed, as per controlled drugs guidelines, as soon as discharge date is known.
- A syringe pump prescription cannot be added as a TTA in Cerner – the medications should be prescribed individually with an accompanying note that they are intended for use in a syringe pump.
- Discuss quantities of ampoules needed for discharge with pharmacy if patient on higher doses or syringe pump.
- Assess if equipment (e.g. needles, syringes, sharps bin, saline or water for injection ampoules) is required.

- If the patient is going home, refer to district nurses as soon as discharge date is known.
- A community authorisation chart (Medications Authorisation and Administration Record (MAAR) chart) must be sent home with the patient in order for medications to be administered in the community – this can found on the End of Life Care Intranet page or can be requested from the SPC Team.
- Ensure a referral is made to the Community Palliative Care Team or updated if the patient is already known to them.
- Contact GP and send discharge summary to **all** of the above.
- A Universal Care Plan (UCP) record should be discussed with patient and NOK.
- Discuss with patient and NOK about reasons for the medications, who will give these injections if they are required and where to store at home.

Pain (Normal Renal Function)

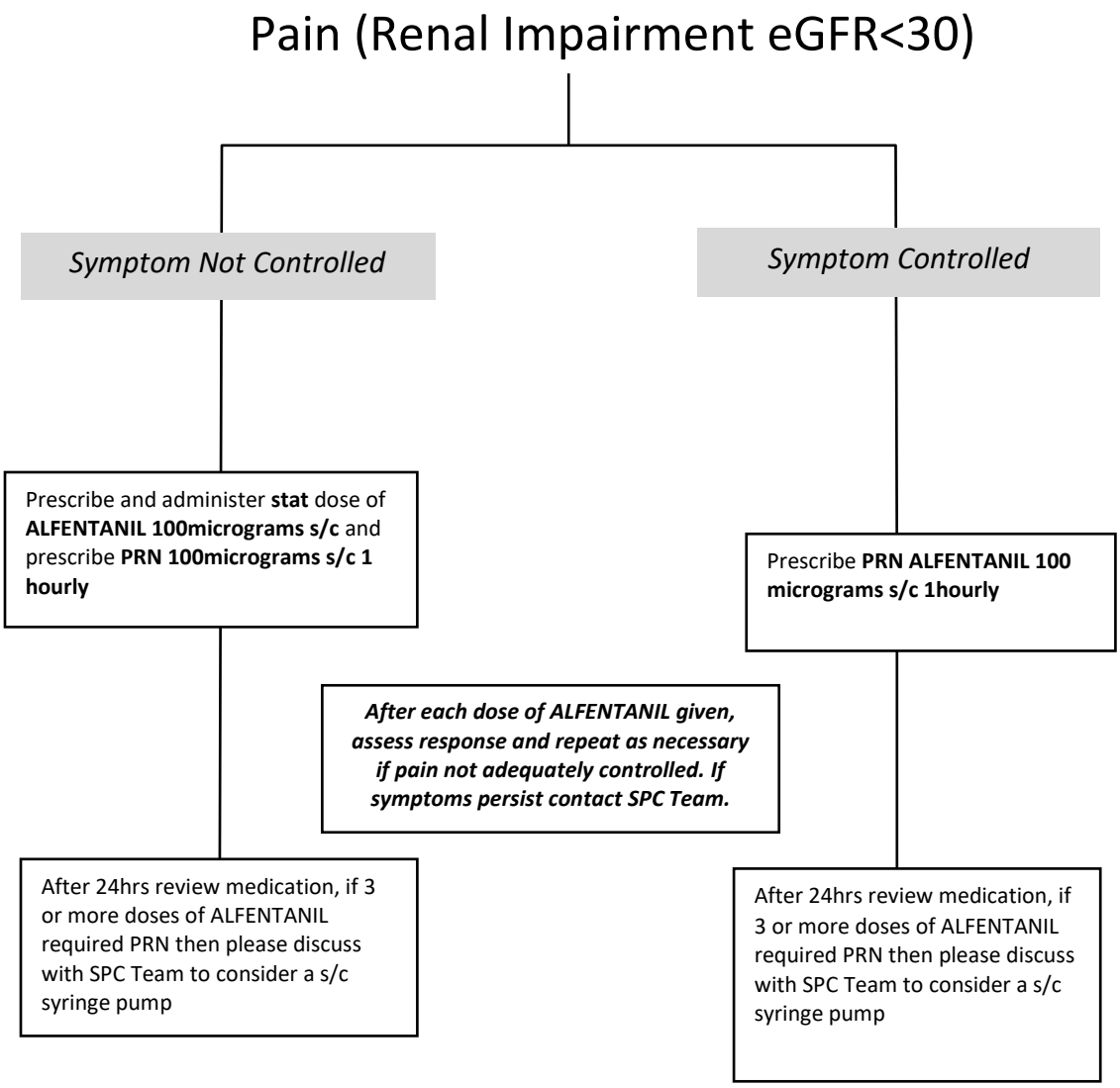


NOTE:

Contact SPC Team if patient is taking a regular oral opioid or has fentanyl/buprenorphine patch applied. DO NOT REMOVE TRANSDERMAL PATCH UNLESS DISCUSSED WITH SPC TEAM.

Consider lower dose of Morphine S/C of 1.25mg and 4hrly frequency in patients with:

- **mild to moderate renal impairment. If eGFR <30, consider using alfentanil.**
- **hepatic failure (raised bilirubin, INR and low albumin or severe cirrhosis +/- encephalopathy/ascites)**
- **COPD or frailty**

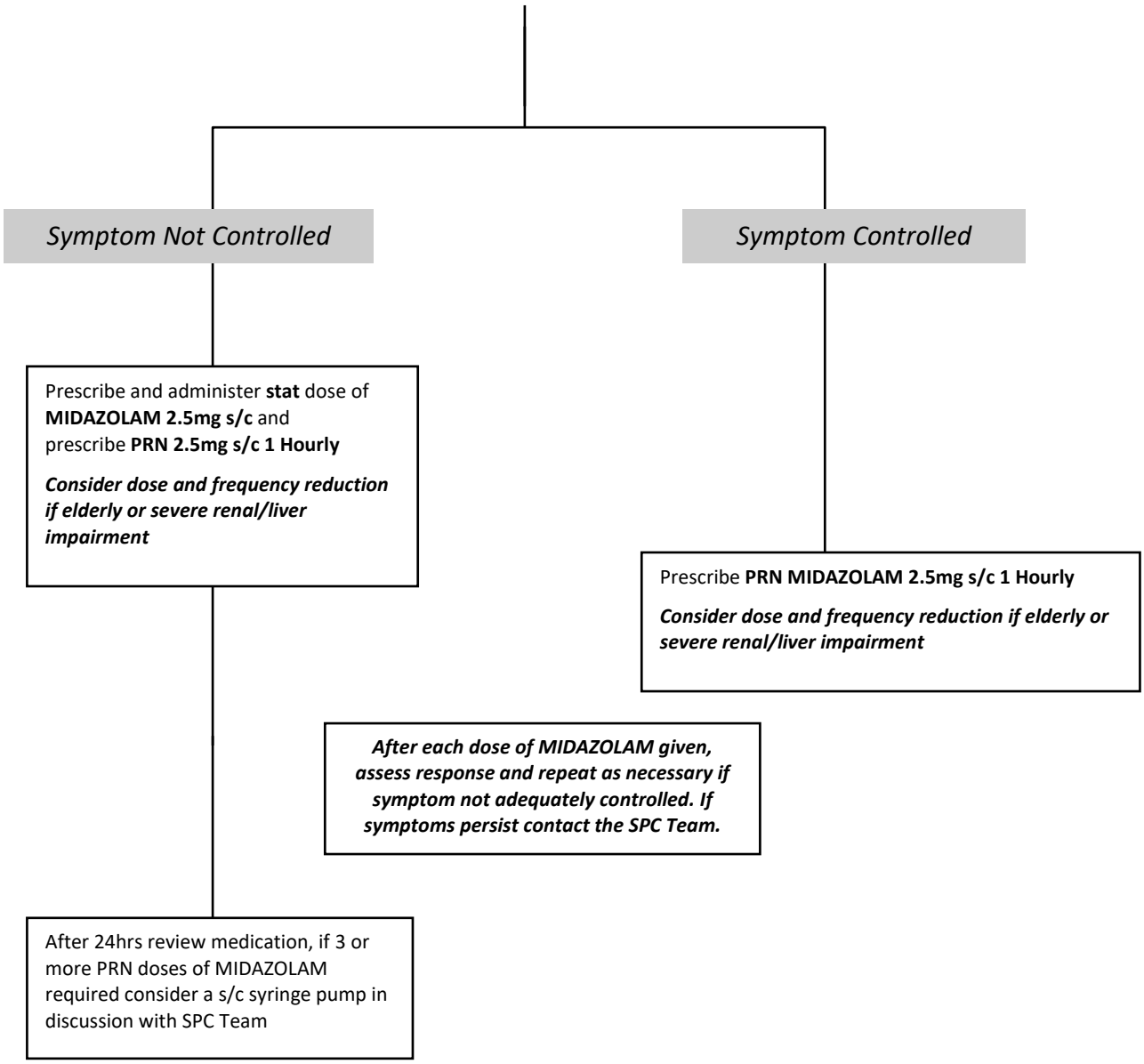


NOTE:

Contact SPC Team if patient is taking a regular oral opioid or has fentanyl/buprenorphine patch applied. **DO NOT REMOVE TRANSDERMAL PATCH UNLESS DISCUSSED WITH SPC TEAM.**

In patients with severe hepatic impairment (raised bilirubin, INR and low albumin or severe cirrhosis +/- encephalopathy/ascites), please discuss with SPC Team.

Terminal Restlessness and Agitation

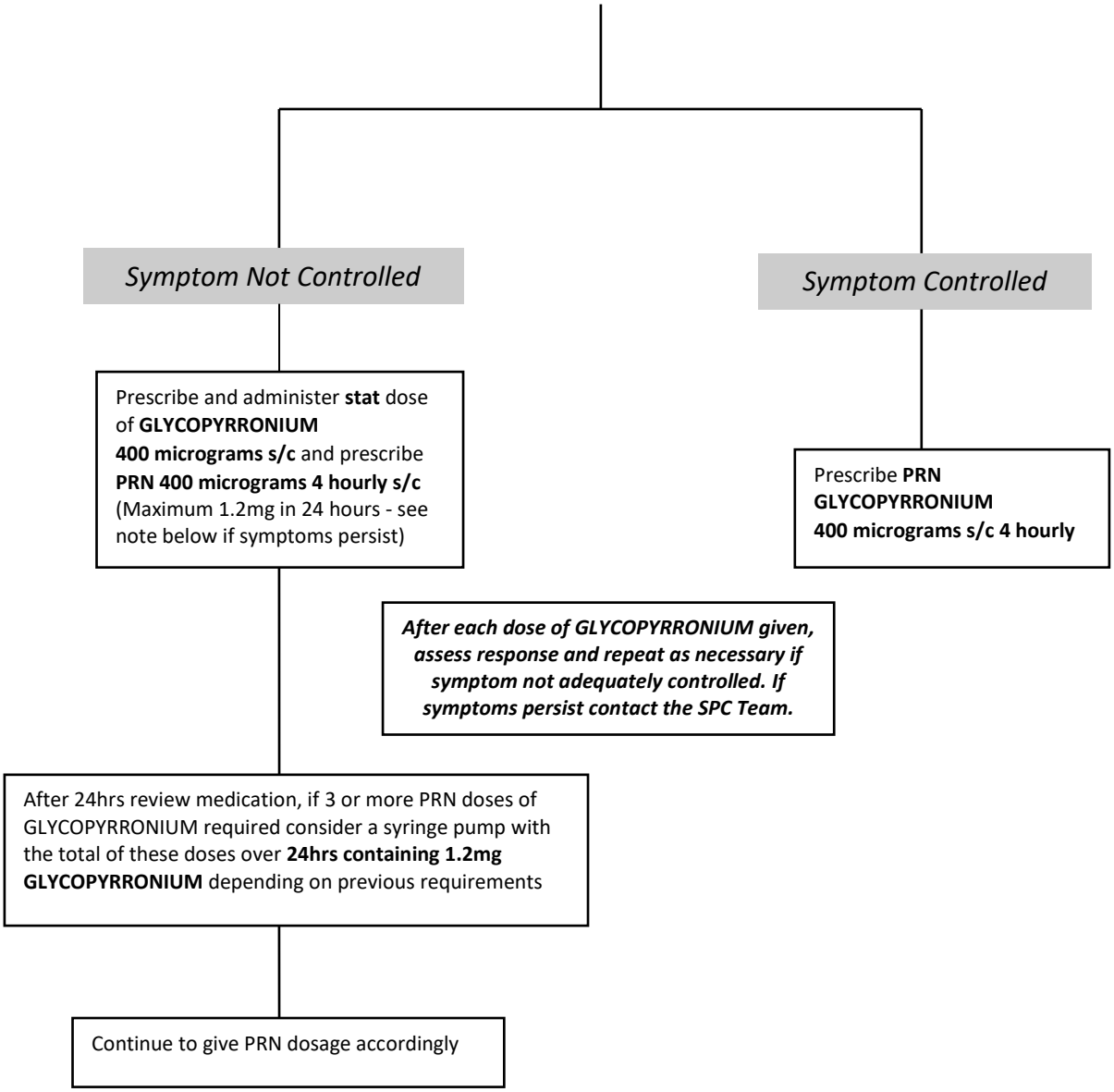


NOTE:

Consider lower dose of Midazolam S/C of 1.25mg and 4hrly frequency in patients with:

- **severe renal failure (eGFR <15)**
- **hepatic failure**
  (raised bilirubin, INR and low albumin or severe cirrhosis +/- encephalopathy/ascites)
- **COPD or frailty**

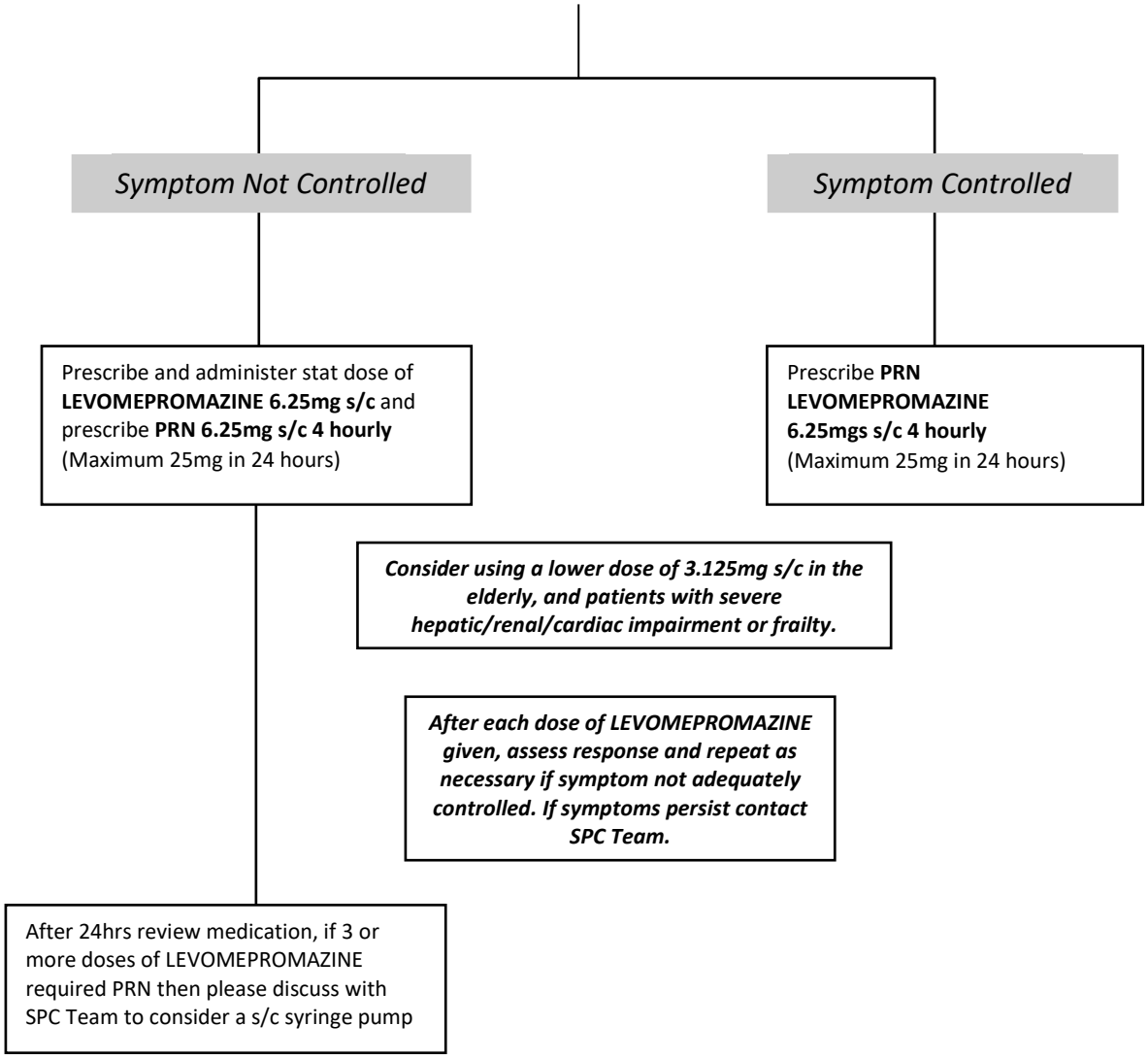
Respiratory Tract Secretions



NOTE:

Increase total 24hr dose of Glycopyrronium S/C to 2.4mg after 24hrs if symptoms persist on 1.2mg/24 hours

Nausea and Vomiting



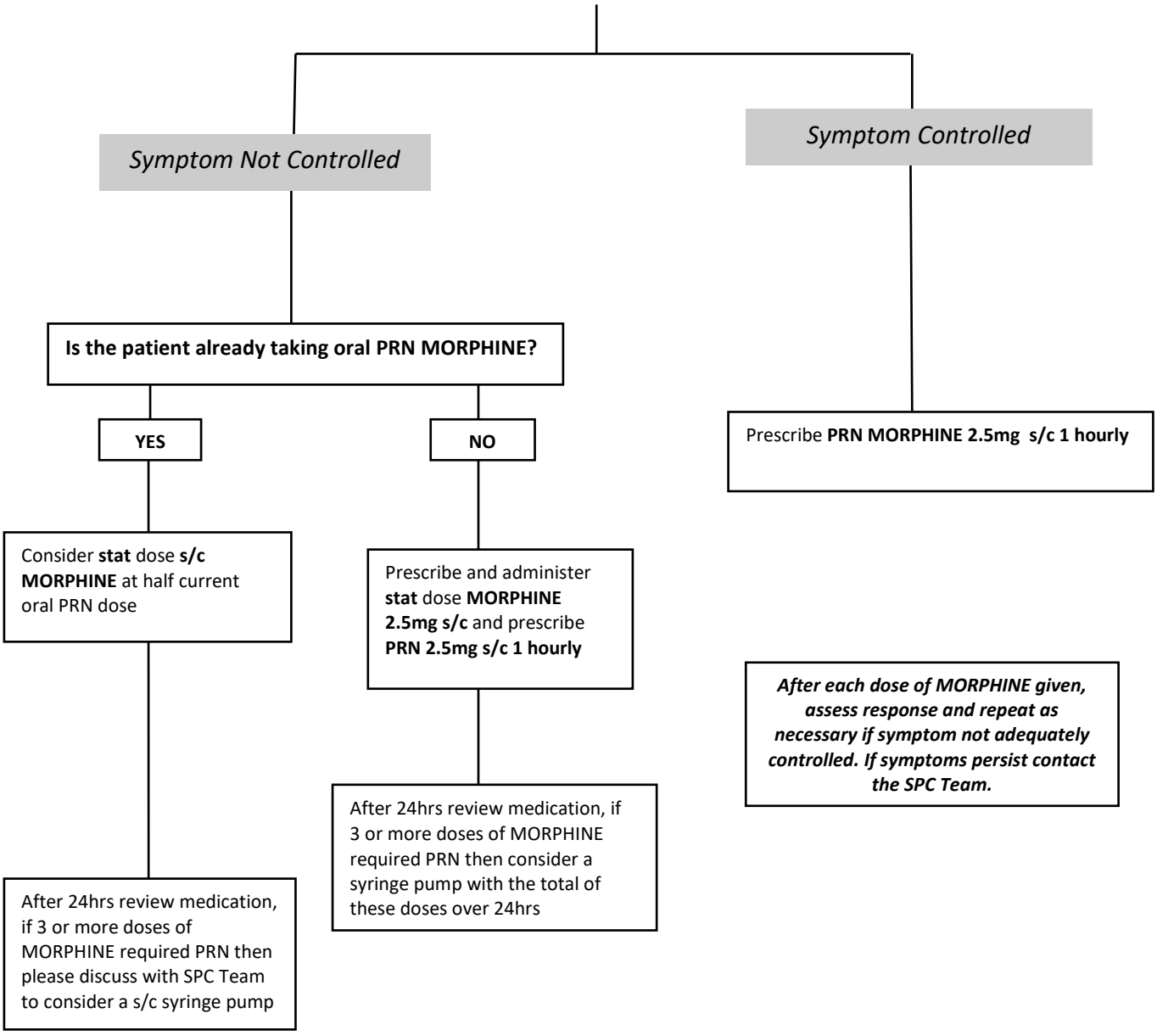
NOTE:

Consider using a lower dose of Levomepromazine S/C of 3.125mg in the elderly, and patients with severe hepatic/renal/cardiac impairment or frailty.

Caution in patients with Parkinson's disease, Lewy body dementia and epilepsy/seizures as it may increase extrapyramidal side effects/lower seizure threshold.

NB. May cause side effect of drowsiness.

Respiratory Distress or Dyspnoea



NOTE:

Contact SPC Team if patient is taking a regular oral opioid or has fentanyl/buprenorphine patch applied. DO NOT REMOVE TRANSDERMAL PATCH UNLESS DISCUSSED WITH SPC TEAM.

Consider lower dose of Morphine S/C of 1.25mg and 4hrly frequency in patients with:

- **mild to moderate renal impairment. If eGFR <30, consider using alfentanil.**
- **hepatic failure**
  (raised bilirubin, INR and low albumin or severe cirrhosis +/- encephalopathy/ascites)
- **COPD or frailty**

If associated anxiety, consider +/- **PRN MIDAZOLAM 2.5mg s/c 1 hourly.**

APPENDIX A

SHORT SYMPTOM CONTROL GUIDE FOR PATIENTS WITH COVID-19

- **Opioids** (in appropriate and judicious doses) are the mainstay of pharmacological management to reduce the sensation of breathlessness and can help support patients to tolerate CPAP/NIV
- **Low dose benzodiazepines** can also be used if there is significant associated fear or anxiety
- **Paracetamol** may also be helpful for reducing fever and associated tachypnoea with respiratory distress
- Ongoing use of PRN doses is encouraged, especially if worsening symptoms
- Remember *non-pharmacological measures*: calm environment, verbal reassurance, cold flannel on cheek, upright positioning.

N.B: There is no evidence that opioids or benzodiazepines cause cardiorespiratory compromise or hasten death if appropriately titrated.

Please seek advice from palliative care team if:

- **Considering starting a syringe pump (continuous subcutaneous infusion CSCI over 24 hrs)**
- **Severe symptoms or distress or symptoms not responding after 2-3 PRN doses**
- **Liver or renal impairment (eGFR <30)**

Contact details for Palliative Care Team
CNS available for face to face reviews and advice on both sites: Mon-Fri 9am-5pm, Weekend/BH 8am-4pm
CWH: Bleep 4026 or Ext 58499 OOH: contact Palliative Medicine StR on-call at Royal Trinity Hospice on 020 7787 1000
WMH: Bleep 018 or Ext 6822 OOH: contact Doctor on call at Meadow House Hospice on 020 8967 5597

Symptom control guidance for breathlessness/respiratory distress forpatients with COVID-19 receiving active treatment

Opioid – 1st line	**Recommendation**
Opioid naïve and **able to swallow**	• **Oramorph 1.25-2.5mg PO PRN 4-6hrly** • If effective, convert ASAP to Morphine Sulphate MR (MST) 5mg PO BD
Patients **unable to swallow**	• **Morphine Sulphate 1.25mg-2.5mg SC 4-6hrly PRN** • If needed regularly, consider starting either 1.25mg -2.5mg Morphine SC QDS or SC infusion via a syringe pump (starting dose Morphine 5-10mg/24 hours)
Patients on regular opioids for pain relief	• Please contact palliative care team for advice
Renal impairment (eGFR <30ml/min)	• Please contact palliative care team for advice
Benzodiazepine – if associated anxiety/agitation	**Recommendation**
Patients **able to swallow**	• **Lorazepam 0.5mg sublingual PRN, max QDS**
Patients **unable to swallow**	• **Midazolam 1.25mg -2.5mg SC PRN 4hrly**

Symptom control and management of dying patients

Guidance on anticipatory medications for patients in last hours to days of life

Symptoms	Drug	PRN s/c dose	Frequency	Usual starting dose for syringe pump (CSCI/24hrs)
Breathlessness/respiratory distress	**Morphine Sulphate**	**2.5mg**	**1 hrly**	5-10mg (if opioid naïve)
Pain	**Morphine Sulphate**	**2.5mg**	**1 hrly**	10-15mg (if opioid naïve)
Anxiety/agitation	**Midazolam**	**2.5mg**	**1 hrly**	5-10mg
Respiratory secretions	**Glycopyrronium**	**400mcg**	**4 hrly**	600-1200mcg
Nausea and vomiting	**Levomepromazine**	**3.125-6.25mg**	**6hrly**	6.25-12.5mg

- **Use lower doses and increased dosing interval in renal or liver impairment or frail/elderly patients**
- **If renal impairment (eGFR <30ml/min) consider using alfentanil as alternative to morphine - PRN dose 100mcg sc stat**

All dying patients should have an **individualised care plan** documented on CERNER which should consider the following:

- **Stopping observations** - unless they will alter management
- **Hydration** - patients may require IV or SC fluids if symptomatic of dehydration and unable to maintain oral intake
- **Regular mouthcare** – continuous oxygen and medications can cause dry mouth and nasal passages
- **Oxygen requirement** – consider weaning oxygen gradually and/or switching to nasal cannulae once the patient is comfortable
- **Family members** – ensure they are regularly updated and involved (by telephone if necessary). Offer visit where appropriate.
- **Spiritual and cultural needs** - where practically possible, offer chaplaincy support

APPENDIX B

Prescribing Syringe Pumps

Quick Reference Guide

This QRG covers how to prescribe using the Syringe Pump PowerPlan.

PowerPlan available:

- Continuous Subcutaneous Syringe Pump (CWFT)

With the patient record open on the page at the top of the left Menu:

1. Click on the **New Order Entry** or plus sign on the Clinician Workflow or
2. Locate the **Orders** component in main menu, and then click the component name.

Ordering the PowerPlan

1. Click the + Add button
2. Start typing the first word of the required PowerPlan in the **Search** field
3. If you have difficulty locating the drug, try clicking the drop-down to the right of the **Search** field to change the **Starts with** option to **Contains**.
4. Click on the relevant PowerPlan
5. Click the Done button

Choose the Order

There are several volume options which make up the PowerPlan.

6. Click on the checkbox for the required order depending on the total volume of drugs
7. The **Interaction Checking** window opens.
   Click OK

Completing the PowerPlan

8. Click on the order which has the missing information mandatory icons
9. Complete all relevant fields on the **Details** Order form (yellow fields are mandatory)
10. Click Orders For Signature
11. Click Sign
12. Click the refresh 0 minutes ago button

Adding drugs to an existing PowerPlan

Each PowerPlan only allows for one prescribing event for each drug. If you need to prescribe further doses of the same drug, you will need to set up a new PowerPlan by clicking Add.

You can add further drugs to an existing PowerPlan, but only if the group has not been administered.

To prescribe further medications from the same PowerPlan:

1. Click the **Orders** page on the left-hand menu.
2. Click to select the PowerPlan from the **View** list on the left
3. Click the **View Excluded Components** button
4. Click to tick further medications as required
5. Complete order details as above
   You will not be prompted to initiate the plan again, as it is already initiated.
6. Click Orders For Signature
7. Click Sign
8. Click the refresh 0 minutes ago button

APPENDIX C

Guidance for TTAs for Anticipatory Injectable Medications at End of Life

Symptom	Drug	Strength	CD requirement	Prescription for TTA
Pain or shortness of breath	**Morphine sulphate** (solution for injection)	10mg/1ml	Yes	Supply ten (10) 1 ml ampoules
Alternative to morphine for pain/SOB (see guidance below)	***Oxycodone*** *(solution for injection)*	*10mg/1ml*	*Yes*	*Supply ten (10) 1 ml ampoules*
	Alfentanil *(solution for injection)* ***Severe renal impairment***	*1mg/2ml*	*Yes*	***Discuss with palliative care team***
Agitation/anxiety	**Midazolam** (solution for injection)	10mg/2ml	Yes	Supply ten (10) 2ml ampoules
Respiratory secretions	**Glycopyrronium bromide** (solution for injection)	600mcg/3ml	No	Supply 10 ampoules
Nausea and vomiting/agitation	**Levomepromazine** (solution for injection)	25mg/ml	No	Supply 10 ampoules

- **Prescribe doses on an individual basis** – please refer to symptom control guidelines (see table below) or seek advice from specialist palliative care (SPC) team. Ranges for doses are preferable in the community setting.
- CD requirement: prescribe **quantity and dose in words and figures**. N.B. cannot be prescribed by FY1 doctors.
- **Supply 10 ampoules of each drug for PRN use** (plus additional if on a continuous subcutaneous syringe pump)
- Complete a **community authorisation chart** (MAAR chart) with appropriate drug and dose range for each symptom with PRN doses and a continuous subcutaneous syringe pump chart if patient to continue on this in the community – check with SPC team
- Include an instruction with **dose, frequency, indication and max dose in 24 hrs**.

Symptom management guidelines for patients being discharged at end of life					
Symptoms	**Drug**	**PRN s/c dose**	**Frequency**	**Suggested max PRN doses total in 24 hrs**	**Notes**
Pain and/or SOB/respiratory distress	**Morphine sulphate***	2.5mg-5mg	1-2 hrly	15mg	Use lower doses for dyspnea (1.25mg)
	Oxycodone*	*1.25-2.5mg*	*1-2 hrly*	*7.5mg*	***Alternative opioids used in renal impairment or morphine intolerance – seek SPC guidance***
	Alfentanil (only under SPC advice)	*100-200mcg*	*1-2 hrly*	*1mg*	
Terminal restlessness /agitation	**Midazolam***	2.5-5mg	1-2 hrly	15mg	
Respiratory tract secretions	**Glycopyrronium**	200-400mcg	4 hrly	1200mcg	
Nausea and vomiting/agitation	**Levomepromazine***	3.125-6.25mg	4 hrly	25mg	Caution with dementia, Parkinson's disease, seizures NB. may cause drowsiness

- ***Use lower doses (1.25mg) and increased dosing interval in renal or liver impairment or frail/elderly patients**
- **Consider using oxycodone instead of morphine if renal impairment (eGFR<60ml/min) – caution as can still accumulate**
- **If severe renal impairment (eGFR <30ml/min) or morphine intolerance please seek SPC advice**
- ***Please also seek SPC advice if starting a syringe pump, symptoms not responding after 3 doses, severe symptoms or distress or any uncertainty about prescribing***