

## Prescribing Guidelines for the Pharmacological Management of Symptoms for Adults in the Last Days of Life

All patients at the end of life are entitled to treatment aimed at optimising their comfort and dignity. The treating team – doctors, nurses and other clinicians - responsible for the care of a dying patient must work together with the patient and/or their decision makers to ensure that the patient receives appropriate, timely and adequate treatment to relieve distress. This often requires prescribing medications for symptom management.

### Anticipatory prescribing

There are several common symptoms that may cause distress in dying patients. Ordering medications ahead of time, '*anticipatory prescribing*', ensures prompt management of these symptoms when they occur.

### When to use these guidelines:

These guidelines outline recommended initial medications, doses and administration regimens for the management of common symptoms in the last days of life. The guidelines can be used in:

- > anticipation of distressing symptoms developing, and/or
- > response to a patient suffering from distressing symptoms.

**These guidelines have primarily been developed for use in SA Health inpatient settings.**

#### BEFORE WRITING UP MEDICATION ORDERS

- > Discuss the need for medications to support symptom management with the patient and/or the patient's decision-maker(s).
- > Review the patient's **current medications** and consider:
  - > ceasing any non-beneficial or burdensome medications
  - > continuing essential medications via the subcutaneous route where possible
  - > potential for development of distressing withdrawal symptoms if specific medications are abruptly ceased (refer to [Medication Cessation for Adults in the Last Days of Life fact sheet](#)).
- > Be aware that the doses of medications outlined in these guidelines may need to be **increased** if the patient is already prescribed analgesics (particularly moderate to high dose opioids), anxiolytics, anti-emetics or anticonvulsants.
- > Check for **allergies** and for potential **contraindications, interactions or side effects**.

#### URGENT CLINICAL REVIEW is required if there is:

- > **inadequate relief** of a symptom despite three maximum doses administered in succession at the shortest specified time interval, **or**
- > any clinical concern.

Further information about symptom management, prescribing or administering medications, or other related issues may be obtained from:

- > Relevant SA Health fact sheets
- > Therapeutic Guidelines: Palliative Care

**Urgent phone advice can be obtained from Specialist Palliative Care Services: contact via the relevant hospital switchboard.**

#### WHILE WRITING UP THE MEDICATION ORDERS

- > Ensure that the **reason** for administering the medication is documented in the '**indication**' box of each medication, using terms consistent with those used in the table overleaf.

#### AFTER MEDICATION ORDERS ARE WRITTEN UP

- > Ensure the patient is reviewed regularly and commence medications in anticipation of, or as soon as symptoms are identified.
- > Review treatment outcome for **effectiveness** and **side effects**.
- > Regularly review the management plan with the patient and/or the patient's decision maker(s).
- > Ensure **handover** to all medical and nursing staff involved in the care of the patient; for example, at shift changes, on transfer of the patient to another ward or facility, or on discharge of the patient.

INDICATION	MEDICATION	DOSE	ROUTE	FREQUENCY	PRACTICE POINTS <i>Dosing should begin with the lower dose in any given range.</i>	
Pain or Dyspnoea	<i>Morphine – pain</i>	2.5mg to 5mg	Subcut	every hour as required	<ul style="list-style-type: none"> <li>&gt; Doses listed are for opioid naïve patients.</li> <li>&gt; Where opioids are already prescribed, convert regular oral opioid dose to the appropriate 24hour subcutaneous dose and administer by a continuous subcutaneous infusion.</li> <li>&gt; HYDROmorphine is approximately <b>FIVE</b> times more potent than morphine.</li> </ul>	
	<i>Morphine - dyspnoea</i>	1mg to 2.5mg				
	<b>If the patient has a contraindication to morphine, for example:</b>					
	<ul style="list-style-type: none"> <li>&gt; <b>known or suspected renal impairment, or</b></li> <li>&gt; <b>an allergy to morphine</b></li> </ul> <b>then give either:</b>					
	<i>Fentanyl</i>	25microgram to 50 microgram	Subcut	every hour as required		
	<b>OR</b>					
	<i>HYDROmorphine</i>	0.5mg to 1mg	Subcut	every hour as required		
Anxiety or Terminal Restlessness	<i>Clonazepam</i>	0.25mg to 0.5mg	Subcut	every 12 hours as required	<ul style="list-style-type: none"> <li>&gt; Clonazepam has a long duration of action and is prone to accumulate and lead to over sedation.</li> <li>&gt; Midazolam has a very rapid onset and short duration of action. It is preferred if amnesia and sedation are required. A subcutaneous infusion is required to achieve sustained effect.</li> </ul>	
	<b>OR</b>					
	<i>Midazolam</i>	2.5mg	Subcut	every hour as required		
Delirium or Agitation	<i>Clonazepam</i>	0.25mg to 0.5mg	Subcut	every 12 hours as required	<ul style="list-style-type: none"> <li>&gt; An antipsychotic may be used as an alternative to or in addition to a benzodiazepine.</li> <li>&gt; Reserve antipsychotics for patients with distressing refractory symptoms using the lowest dose possible. Refer to <a href="#">Clinical Guideline</a> for advice.</li> <li>&gt; Avoid haloperidol in Parkinson's Disease or if extrapyramidal side effects are distressing; olanzapine is preferred. <i>Seek specialist palliative care clinician advice.</i></li> </ul>	
	<b>OR</b>					
	<i>Midazolam</i>	2.5mg	Subcut	every hour as required		
	<b>AND / OR</b>					
	<i>Haloperidol</i>	0.5mg to 1mg	Subcut	every 2 hours prn; suggested maximum 5mg in 24 hours		
Nausea	<i>Metoclopramide</i>	10mg	Subcut	every 4 hours prn, to a maximum of 30mg in 24 hours	<ul style="list-style-type: none"> <li>&gt; Metoclopramide is contraindicated in suspected bowel obstruction</li> <li>&gt; Avoid using metoclopramide and haloperidol in Parkinson's Disease or if extrapyramidal side effects are distressing; ondansetron is preferred. <i>Seek specialist advice.</i></li> </ul>	
	<b>OR</b>					
	<i>Haloperidol</i>	0.5mg to 1mg	Subcut	every 4 hours prn; suggested maximum 5mg in 24 hours		
Gurgly / Noisy Breathing	<i>Hyoscine butylbromide</i>	20mg	Subcut	every 2-4 hours as required; maximum 120mg in 24 hours	<ul style="list-style-type: none"> <li>&gt; Start early and evaluate response. Cease therapy if ineffective after 3 consecutive doses</li> </ul>	

### Required ward imprest list

Clonazepam 1mg/mL injection	Midazolam 5mg/mL injection
Haloperidol 5mg/mL injection	Metoclopramide 10mg/2mL injection
Hyoscine butylbromide 20mg/mL injection	Morphine 10mg/mL injection
Fentanyl 100microgram/2mL injection OR HYDROmorphine 2mg/mL injection	

For further information: [www.sahealth.sa.gov.au/lastdaysoflife](http://www.sahealth.sa.gov.au/lastdaysoflife)

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