Palliative Care Out-of-hours.
A resource pack for West Dorset

Contents:

Section 1

Supply of drugs for palliative care patients.

There are different sources for drugs you may need for palliative care:

1. DDoc stock box that may be useful for palliative care – see Appendix 1 for list
2. Hospital pharmacy – see below for opening hours,
3. The on-duty community pharmacists – remember also Safeway pharmacy is open 9.00am – 7.00pm on Saturdays and 10.00am to 4.pm on Sundays
4. Community pharmacists who have agreed to be approached for out of hours – see below
5. What you may carry in your own bag

NB though DDoc carries no controlled drugs, the base / car box does have **one bottle of Oramorph Suspension 10 mg / 5ml** for use in palliative care.

If you use this please write a prescription of the patient to whom it was given, get patient or carer to sign the exemption statement on the back and obtain a replacement from a local pharmacy at the earliest opportunity.

Hospital Pharmacy hours.

The DCH hospital pharmacy is now open 7 days a week.

Saturday	9.30 am - 2.30 pm
Sunday	10.00 am - 2.00 pm

They are happy to supply drugs including opiates for community patients against an FP 10, if these are not available from the duty community pharmacist.

They will supply these drugs to the patient or his or her representative including a district nurse or Ddoc doctor.

The on-call hospital pharmacist is also available via a pager through switchboard DCH at other times should there be an urgent need for supply of medication.

There is no pharmacy at Bridport Community Hospital

Supply of drugs outside pharmacy hours.

A number of local pharmacists in Weymouth, Dorchester and Bridport (Ideal Healthcare for Weymouth & Portland, Market Pharmacy for Dorchester area & Moss Pharmacy for Bridport) have allowed their home numbers to be held by DDoc control and have said they will, if they are available, come in to their pharmacies to dispense medicines required urgently for palliative care.

The hospital has an on-call pharmacist available 24 hours a day for genuine emergencies – see above

A list of drugs the community pharmacists should usually have in stock is in Appendix 2.

Information.

In Section 2, Clinical Information, of this pack there are suggestions for the drug treatment of specific symptoms. There is also a guide to the opiate dose required for breakthrough pain, to transferring from oral morphine to parenteral diamorphine and information about transdermal fentayl (Durogesic)

There is a good section on prescribing in palliative care at the beginning of BNF, there is a copy of the Palliative Care Formulary (PCF) at the Dorchester base and Bridport community hospital wards.
The is also a copy of the little pale green Palliative care Handbook in this pack

Advice is always available from the nursing and medical staff at Joseph Weld Hospice (01305 251052).

www.palliativedrugs.com also holds the information in the PCF as well as details about syringe driver compatabilities etc
www.sign.ac.uk The Scottish Intercollegiate Guidelines site also has a good section on cancer pain . It gives information about drug compatibilities (SIGN Guideline 44 at http://www.sign.ac.uk/pdf/sign44.pdf page 67 in Annex 9.)
www.pallmed.net Website conceived and maintained by Dr Ian Back, Consultant in Palliative Medicine, U.K.

Section 2. Clinical Information

Guidelines for symptom management on single sheets are at the back of this pack (Appendix 3) They cover:

- Pain
- Nausea
- Restlessness and agitation
- Breathlessness
- Excess secretions
- Intestinal obstruction
- Spinal cord compression
- Use of fentanyl

- **Conversion from oral morphine to continuous parenteral diamorphine by syringe driver**.
  - Take total 24 hour dose of morphine in mg and give **one third** of this in mg of diamorphine over 24 hours.

- **Calculating the dose required for breakthrough pain relief**
  - This should usually be one sixth the total daily opiate dose.
  - If on fentanyl patch divide patch strength by five and give this dose as mg diamorphine (eg if using Fentayl 25 mcg patch dose is 25/5 = 5 mg diamorphine as required

- **Adding opiates to fentanyl (Durogesic) patch – usually the recommended way.**
  - Let the patch remain in place and continue to change it every 72 hours
  - add diamorphine by syringe driver using total dose required for breakthrough pain over past 24 hours to or by giving 2 times the single breakthrough dose calculated as above over the first 24 hours and three times the breakthough dose thereafter.

- **Replacing fentanyl patch with diamorphine by syringe driver (Not usually recommended – see above)**
  - Remove the patch
  - Calculate diamorphine dose by dividing the patch strength by 2 and give this dose over 24 hours
  - After 24 hours give whole of the patch strength as diamorphine over 24 hours

- **Indications for using a syringe driver**
  - Uncontrolled nausea and / or vomiting
  - Bowel obstruction
  - Severe weakness
  - Dysphagia
  - Maintenance of symptom control in the dying phase

- **Syringe drivers out of hours**

Most district nurses have access to a syringe driver.

There is also one held at Joseph Weld Hospice for community use (with full instructions for setting up) but the drugs must be obtained from community pharmacists. The nurse in charge at JWH will know where it is.

Section 3. Last days of life (See Appendix 4 for brief pathway)

- Recognising that a patient is in his or her last days of life is important.

Suggested criteria to decide when patient is dying:

The multiprofessional team have agreed the patient is dying ❑

Intervention for correctable cause has been considered and is not possible/appropriate ❑

<u>and</u>: two of the following apply:-

The patient is:

- bedbound ❑
- Semi-Comatose ❑
- Only able to take sips of fluids ❑
- No longer able to take tablets ❑

If these criteria are fulfilled it may be appropriate to follow the Last days of life integrated care pathway (ICP). A brief version is in Appendix 5 .
This is just a checklist to help us all deliver the best possible care for the patient and family. Main features include:

- Stop inappropriate medications and procedures.
- Consider alternative routes of drug administration and write up medication for pain, nausea, restlessness and excess secretions in anticipation.
- Consider a urinary catheter.
- Check that key people are aware and prepared for the death.

Minimal protocol for care of the dying

1. Make diagnosis that the patient is dying – signs of the terminal phase (see above)
2. Current medication assessed, non essentials discontinued, essential treatment converted to s/c route by syringe driver.
3. PRN drugs written up for pain, agitation, respiratory secretions, nausea and vomiting. (See sheets in appendix 3)
4. Ensure carers know that the patient is dying.
5. Spiritual and religious needs of patient and carers assessed and met.
6. Make an agreed plan for ongoing assessment and care – symptom control, mouth and pressure care, psychosocial support.
7. Relatives are aware what to do when patient dies at home.
8. Communication with others – handover form for out of hours providers, secondary and specialist services informed and hospital appointment cancelled after death

Avoiding inappropriate transfer or admission.

A number of patients are admitted to Dorset County Hospital and die there within 48 hours of admission from home, residential or nursing home or community hospital. Where the death can be anticipated and no specific appropriate interventions are likely to be used at DCH it may be preferable to try to avoid these admissions with the attendant discomfort to patients and inconvenience and distress to relatives.

Please stop and think if there are other ways of meeting the needs of the patient and carer that allow admission to be avoided.

The principles of a good death

- to know when death is coming, and to understand what can be expected
- to be able to retain control of what happens
- to be afforded dignity and privacy
- to have control over pain relief and other symptom control
- to have choice and control over where death occurs (at home or elsewhere)
- to have access to information and expertise of whatever kind is necessary
- to have access to any spiritual or emotional support required
- to have access to hospice care in any location, not only in hospital
- to have control over who present and who shares the end
- to be able to issue advance directives which ensure wishes are respected
- to have time to say goodbye, and control over other aspects of timing
- to be able to leave when it is time to go, and not have live prolonged pointlessly.

(Debate of the age health and care study group. *The future of health and care of older people: the best is yet to come* London ,Age Concern 1999)

Appendix 1
Drugs in standard DDoc Box that may be appropriate for palliative care.

Nausea & vomiting

Parenteral

Prochlorperazine (Stemetil) Inj 12.5 mg
Haloperidol Inj 5mg/1ml

Oral

Prochlorperazine (Buccastem) Tabs
Metoclopramide Tabs10mg

Analgesia

Parenteral

Diclofenac Supps 100mg
Diclofenac Inj 75mg/3ml

Oral

Paracetamol Tabs500mg
Codeine Phos Tabs15mg

For restlessness, agitation, fitting

Parenteral

Diazepam (Valium) 10mg/5ml Injection NB NOT suitable for syringe driver use
Diazepam(Stezolid) Rectal

Steroid

Oral

Prednisolone (Prednesol) Sol. Tabs 5mg

Drug	Form	Quantity
Cyclizine 50mg/ml	Injection	10 x 1ml
Dexamethasone 4mg/ml	Injection	10 x 2ml
Diamorphine 5mg	Injection	10
Diamorphine 10mg	Injection	10
Diamorphine 30mg	Injection	10
Diamorphine 100mg	Injection	10
Diazepam 10mg	Rectal Tubes	5
Diclofenac 100mg	Suppositories	10
Fentanyl 25mcg/hr	Patches	1 x 5
Haloperidol 5mg/ml	Injection	5 x 2ml
Hyoscine Butybr 20mg/ml	Injection	10 x 1ml
Hyoscine HBr 400mcg/ml	Injection	10 x 1ml
Methotrimeprazine 25mg/ml	Injection	10 x 1ml
Metoclopramide 5mg/ml	Injection	12 x 2ml
Midazolam 5mg/ml	Injection	10 x 2ml
Oramorph 10mg/5ml	Oral Solution	5 x 100ml
Sodium Chloride 0.9%	Injection	10 x 10ml
Water for Injection		10 x 10ml

Appendix 2 Drugs held in stock by nominated local pharmacies