

Palliative Care Pocket Guide

NHS
Humber Teaching
NHS Foundation Trust

Quick reference for
End-of-Life Care



Caring, Learning
& Growing Together

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This is a guide to the management of adult palliative care patients. The choice of medicine and dosage remains the responsibility of the clinician. For further advice please contact your local specialist **Palliative Care Team.**

Quick contacts...

Saint Catherines Hospice

 **01723 351421**

OHH GP

 **111**

Palcall (OOH)

 **01723 354506**

Medequip

(08:00-17:00)

 **01423 226240**

St. Leonards Hospice

 **01904 708553**

CNS team Saint Catherines OOH

(Weekends & Bank Holidays 08:30-16:30)

 **01723 345506**

Is the patient in pain?

YES

NO

Are there any potential reversible causes that can be managed given likely limited time?
E.g. constipation, retention, psychological distress, position.

Ensure anticipatory medication prescribed and available. Check correct PRN dose prescribed (see key points below). Give reassurance and support to family.

NO

YES

Is the oral route still viable and oral PRN available?

Treat reversible cause, review and seek advice. Encourage use of usual analgesics whilst waiting review

YES

NO

Encourage patient to take dose of PRN analgesic, review after 1 hour. Will need GP or OOH review if still in pain.

If patient opioid naïve give Morphine 2.5mg – 5mg SC +/- other anticipatory medicines as indicated.

If patient taking regular opioid give SC PRN dose. This is patient specific and should be calculated below:

- 24-hour total opiate, divide by 2 to get dose for CSCI. Then divide this by 6 to get SC dose. Dose can be repeated after 2 – 4 hours if needed. Consider CSCI if needing multiple PRNs.

Review and seek specialist advice if needed.

Key points:

- Pain is total and can include physical, psychological and spiritual elements. All need to be managed together for optimal effects.
- Often several pains coexist together. Each require a full pain assessment in isolation for optimal diagnosis and treatment.
- Pain can be common and difficult to manage; expectations of the patient and family must be managed carefully.
- Route should be by mouth if able unless contraindicated, e.g. loss of swallow, absorption issues, unconscious.
- PRN dose should be 1/6th of 24-hour opiate use including patches and anything given PRN orally or SC.
- Adjuvants (Gabapentin, Dexamethasone) can be used on their own or in combination.
- Renal impairment: Start low and titrate slowly monitoring for opioid toxicity. Consider oxycodone if side effects develop.

Symptoms include:

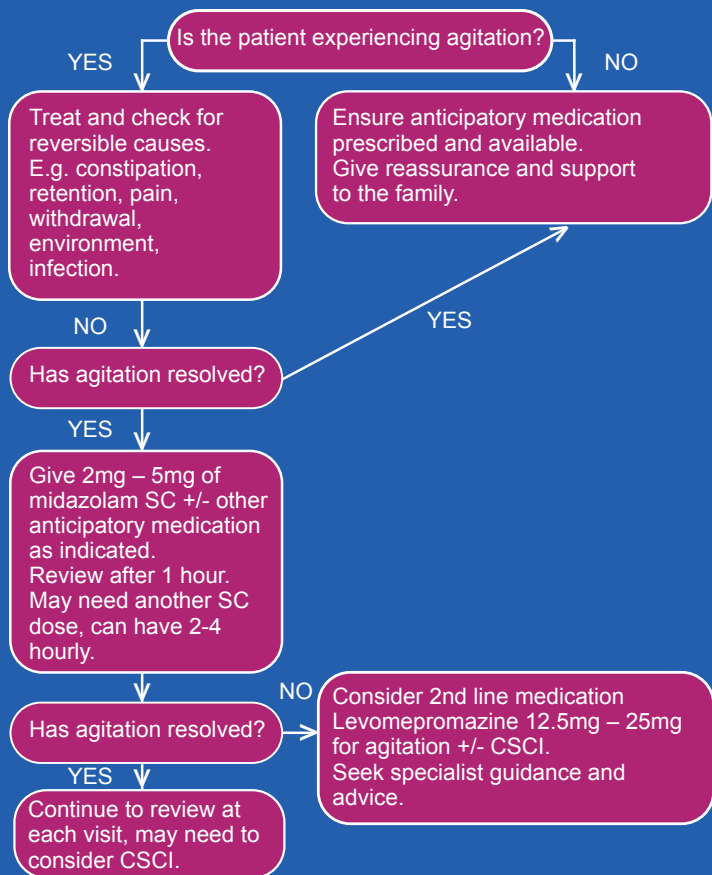
- Persistent sedation (exclude other causes).
- Vivid dreams, hallucinations, shadows at the edge of visual field.
- Delirium.
- Muscle twitching/myoclonus/jerking.
- Abnormal skin sensitivity to touch, itching.

Key points:

- Can be caused by several factors including rapid dose escalation, renal impairment, sepsis, electrolyte abnormalities, drug interactions.
- Wide variation in the doses of opioids that can cause symptoms of toxicity.
- If the pain is controlled reduce the opioid dose by a third. Ensure the patient is well hydrated. Seek advice.

- If patient still in pain, consider reducing opioid dose by a third. Consider adjuvant analgesics, alternative opioids or both. Seek specialist advice.
- Naloxone is only needed for life-threatening respiratory depression.

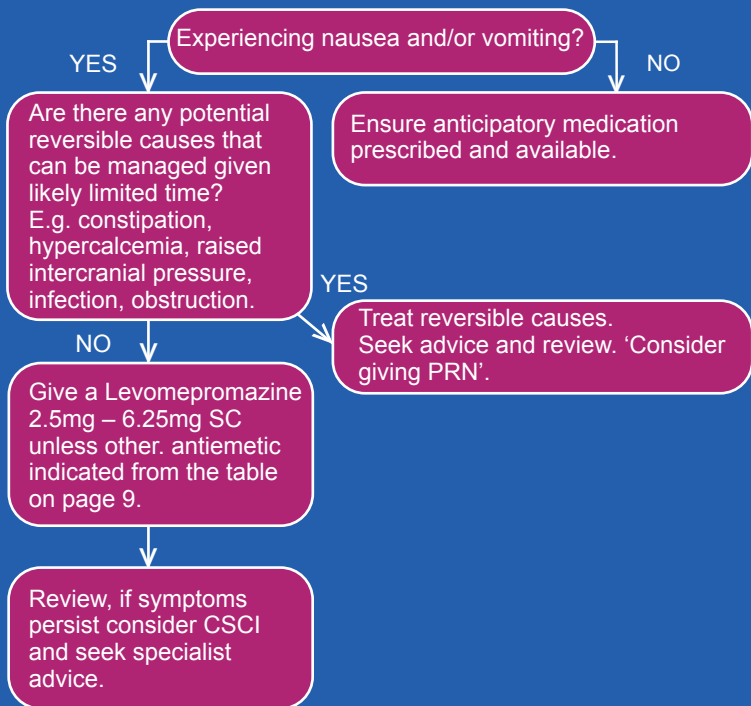




Key points:

- Terminal agitation very common and action needed quickly to resolve if suspected.
- If 2nd line medication Levomepromazine needed ensure agitation dose given 12.5mg – 25mg.
- If patient not responding to 1st or 2nd line medications, seek urgent specialist palliative advice.
- Ensure reversible causes of agitation have been considered and documented.

Nausea and vomiting



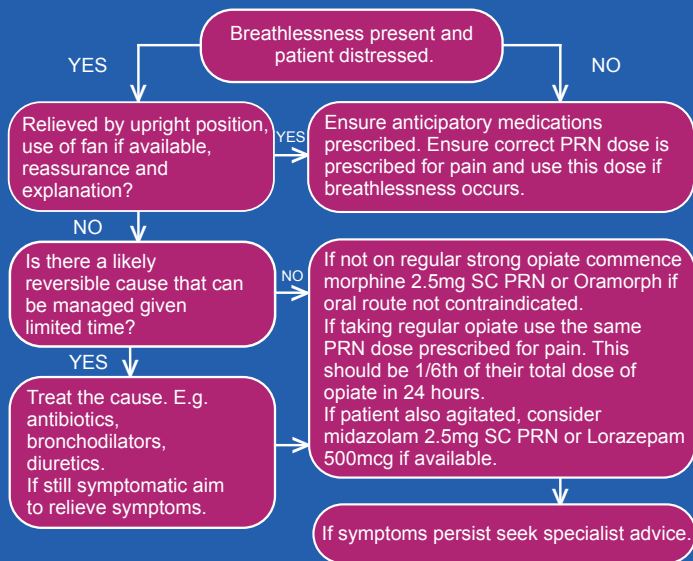
Drug	Indications	Cautions to consider
Levomopromazine	Broad spectrum antiemetic.	Sedation can occur at high doses. Avoid in Parkinson's and Lewy bodies disease.
Haloperidol	Chemical or metabolic causes.	Avoid in Parkinson's disease.
Cyclizine	Raised ICP and bowel obstruction.	Avoid in heart failure.
Metoclopramide	Gastric stasis, prokinetic, pushes gut contents forward.	Stop if colic develops. Avoid in Parkinson's and Lewy bodies disease.
Ondansetron	Intractable vomiting, chemical, abdominal or cerebral causes. Often 2nd or 3rd line choice.	Significantly constipating. Not 1st line.

Key points:

- For patients with Parkinsonism or Parkinson's Disease seek specialist advice.
- Patients with complete bowel obstruction and nausea or vomiting should not receive metoclopramide.

- Metoclopramide and cyclizine should not be prescribed simultaneously as they have opposing effects.
- It may be necessary to combine antiemetics with adjuvants such as corticosteroid and/or benzodiazepine.

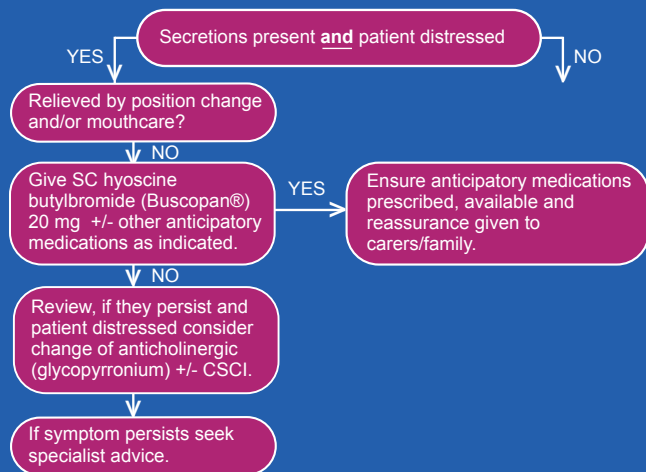
Breathlessness



Key points:

- Simple measures such as a calm environment, a fan or open window can be just as effective as medication.
- 3 or more PRN doses taken in 24 hours for all indications (pain, breathlessness and cough) should trigger a dose review.
- Oxygen not usually helpful and would only be considered to treat hypoxia and after careful individual assessment.

Secretions



Key messages:



- Medications should only be given if there is distress for the patient and clinically indicated. Most secretions do not cause the patient any distress but distress the family.
- Anticholinergics can cause severe side effects such as agitation/confusion, blurred vision, retention, rash, redness to skin and feeling hot. This should be explained to the family.
- If no medications clinically indicated, full explanation and reassurance should be given to the family.
- If hyoscine butylbromide (Buscopan®) ineffective do not repeat doses as has poor efficacy.

Patient having seizure

YES

Keep patient safe, loosen clothing around neck, remove objects that could cause safety issues and give reassurance to family and patient. Time the start of seizure.

NO

Ensure anticipatory medications prescribed and available. Consider whether patient at risk of future seizures and if seizure plan required.

Consider reversible causes, e.g. blood glucose levels, withdrawal, hypercalcaemia.

Is seizure lasting longer than 5 minutes?

NO

Monitor and give reassurance and support. Seek advice and guidance re CSCI or oral antiepileptic medications

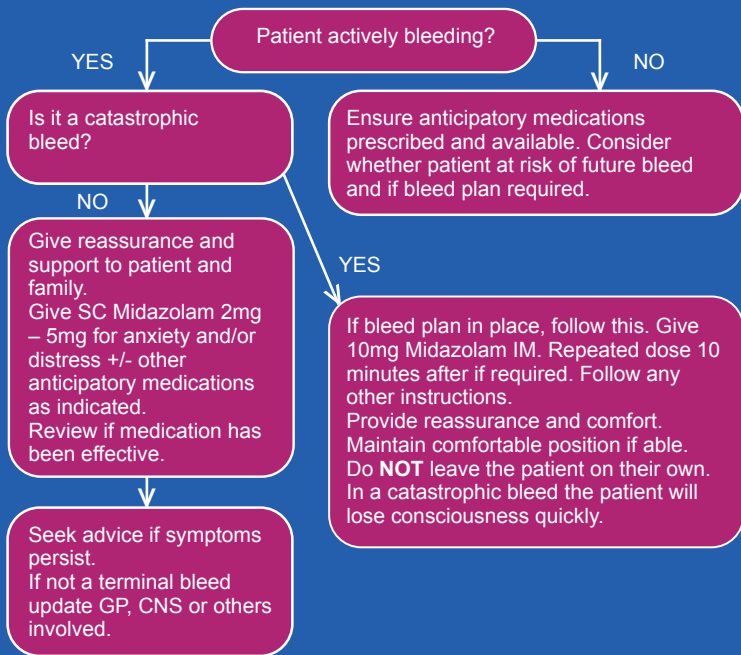
YES

If seizure plan in place, follow this. Usually, 10mg Midazolam IM. Repeated dose 10 minutes later may be required. If no plan in place administer Midazolam 5mg SC and seek urgent specialist palliative advice. Inform all involved (GP, CNS, specialists) of seizure and seek review.

Key points:



- 30% of patients with primary brain tumours have a seizure in the last week of life.
- Haloperidol and levomepromazine can lower seizure threshold, review need and dose if there is definite exacerbation of seizure activity as a result.
- May need to consider commencing corticosteroid or reviewing current dose of it.
- Levetiracetam (Keppra) is usually given alone in CSCI and must not exceed 2g in 30ml syringe.
- Seizures are frightening for patients and their families. Educate and address any concerns whilst giving reassurance and support.
- Staff members are encouraged to debrief after difficult seizure events.



Key points:

- Midazolam will NOT stop bleeding; it is used to relieve patient distress and anxiety during the event.

- It is more important to stay with the patient than leave them alone to get medications, in a catastrophic event death is imminent.
- Provide the Trusts bleed boxes to patients at risk of bleeding events.
- Bleeding is a frightening experience for patients, families and staff. Support and reassurance after the event is paramount.

Syringe drivers (CSCI)

Pros:

- Avoids peaks and troughs of drug level in blood.
- Often avoids repeated injections.
- Patient reviewed regularly as syringe needs replenishing every 24 hours.
- Control of multiple symptoms with a combination of drugs.

Cons:

- Irritation or erythema and swelling at the site which may interfere with the rate and absorption.
- Patient and family perception, they may be fearful it will quicken death.
- Can be difficult with very agitated/restless patients who are at risk of pulling it out.

Key points:

- Generally, incompatible drugs cause precipitation and cloudiness in the syringe. Do not use if this happens and seek advice.
- Site irritation may be reduced by diluting the drugs in a greater volume of diluent.
- Volume 17ml in 20ml syringe or 23ml in 30ml syringe.
- Any 3 of these medications Morphine or Oxycodone, Midazolam, Haloperidol, Hyoscine Butylbromide and Levomepromazine can be combined in one syringe.

- Increases in CSCI doses are usually by 30% - 50%, unusual without specialist advice to increase more than 50%.
- You should avoid oedematous tissue when siting.

Communication with families and difficult conversations

Use SPIKES framework:

- Setting: ensure privacy.
- Perception: What do they understand?
- Invitation: Ask how much they want to know.
- Knowledge: Share information clearly, no jargon.
- Empathy: Respond to emotions.
- Summary: Agree next steps.

Opening conversations:

- 'What matters most to you right now?'
- 'Would you like me to explain what we might expect?'
- 'What is your understanding of where things are right now?'

Responding to distress:

- Name the emotion e.g. 'I can see this is overwhelming'. People will generally correct you if you say the wrong emotion and continue to talk.
- Understand and validate them e.g. 'I'm sorry that things are getting more difficult', 'anyone in your position would feel like this'.
- Reassure the person 'You are doing everything you can', 'Reduced eating and drinking is a natural part of the body slowing down', 'Changes in breathing and secretions are expected and not usually distressing to them'.

- Explore further, 'Tell me what worries you the most'.

Explaining dying:

- Be honest, do not give false hope.
- Use clear language and explanations e.g. 'The body is slowly shutting down, its normal for you/them to sleep more and not eat or drink', 'Time is likely short now, days rather than weeks and our priority is comfort'.
- Use the carers booklet to help explain the last weeks and days of life.

Recognising dying

Dying is a clinical judgement based on overall deterioration, not usually a single sign.

Key clinical indicators:

- Decline in function, bedbound, weakness, dependant for care.

- Limited oral intake, difficulty taking medications, little or no food/water.
- Consciousness, increasing drowsiness, reduced responses, unconscious.
- Breathing, irregular breathing, periods of apnoea, noisy secretions.
- Circulation, cool to touch, mottled skin, weak thready pulse.
- Decline over weeks/days (sometimes hours).

Actions if dying is recognised:

- Communicate with family/carers.
- Inform usual GP/care team.
- Ascertain wishes if not known and prioritise comfort.
- Ensure anticipatory medications in place, if not escalate same day.
- Check ReSPECT and resus status.

OOH decision making and escalation



Same day escalation to either GP, CNS or OOH GP:

- Uncontrolled pain or agitation not eased by PRNs or usual medications.
- Loss of swallow with no SC medications in the home.
- Family unable to cope.
- New confusion/delirium.
- Symptoms not controlled after 1-2 PRNs.

Consider hospital admission if:

- Dying not recognised/anticipated and cause unclear.
- Reversible condition suspected.

- ReSPECT form states would accept hospital admission.
- Unsafe to remain at home (patient or family safety issues).
- No other alternative and cannot remain at home, e.g. hospice admission.

Avoid hospital admission if:

- Expected dying.
- Symptoms manageable with available medications.
- Patient/family wishes to remain at home.
- Family informed and supported.
- Prognosis very limited and death expected imminently.



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Humber Teaching NHS Foundation Trust

Trust HQ, Block A, Ground Floor, Willerby Hill, Beverley Road, Willerby,
East Riding of Yorkshire, HU10 6ED



General Enquiries:
(01482) 301700



hnf-tr.communications@nhs.net



www.humber.nhs.uk



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