ANTICIPATORY PRESCRIBING FOR PATIENTS AT END OF LIFE WITH RENAL IMPAIRMENT (eGFR less than 30)

Document Control:

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Version History:

Version	Date	Author	Reason/Change
V1.0	January 2014	Specialist Palliative Care Team	To originate document
V9.0	January 2023	Consultant Physician, Palliative Care	Transfer to new template
V10.0			

Previous Titles for this Document:

Previous Title/Amalgamated Titles	Date Revised
None	Not applicable

Distribution Control

Printed copies of this document should be considered out of date. The most up to date version is available from the Trust Intranet.

Consultation

During its development this guideline has been circulated for comment to all medical members of the palliative care team. It has been discussed in Palliative Care clinical governance meetings, and the group was happy with the guideline and minor typing errors and grammatical errors were addressed.

Monitoring and Review of Procedural Document

The document owner is responsible for monitoring and reviewing the effectiveness of this Procedural Document. This review is continuous however as a minimum will be achieved at the point this procedural document requires a review e.g. changes in legislation, findings from incidents or document expiry.

Relationship of this document to other procedural documents

This document is a clinical guideline applicable to Norfolk and Norwich NHS Trust please refer to local Trust's procedural documents for further guidance, as noted in Section 4.

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1. Introduction

1.1. Rationale

As people approach the end of their life, they may develop symptoms which can be distressing both for the patient themselves, but also for their family and loved ones. National guidance, strategies and statements have identified the importance of managing these symptoms to ensure good quality of care for the dying patient (NICE Guideline [NG31] 2015; “One Chance to Get it Right”, 2014). The prescribing of medications to help manage these symptoms in anticipation of the symptoms arising, is recognised as good practice. However, these medications, particularly opioids used for pain management have to be used with caution in people with renal failure to ensure that symptom management is carried out safely, without adding to the patient’s burden of symptoms, impairing their quality of life or expediting their death. This is particularly the case in patients with an eGFR less than 30. This guideline has been developed to facilitate the safe, effective prescribing of anticipatory symptom management medication in this patient group.

1.2. Objective

To provide guidance for doctors prescribing anticipatory medications for symptom management for patients with an eGFR less than 30ml/min who are approaching the end of their life. To ensure consistent, safe and effective prescribing for this population.

1.3. Scope

This guidance is intended for use in adults with an eGFR <30 who are thought to be in the final hours or short days to weeks of life.

1.4. Glossary

The following terms and abbreviations have been used within this document:

Term	Definition
eGFR	Estimated glomerular filtration rate
SPCT	Specialist palliative care team
PRN	Pro re nata
SC	Subcutaneous (route for administration of medications)
Anticipatory prescribing	The prescribing of parenteral medications used to manage the symptoms that are commonly experienced in dying patients prior to those symptoms arising.

2. Responsibilities

- Dr Fergus Maher, Consultant Physician
- Dr Caroline Barry, Service Director
- Julie Noble, Lead Nurse Specialist
- Dr Lou Grant, Clinical Governance Lead

3. Anticipatory Prescribing Algorithms for Patients at End of Life with Renal Impairment

3.1. Management of Pain

- Please refer ALL patients on Methadone or Ketamine to SPCT for advice.
- Patients on fentanyl patch should continue patch in addition to the following guidelines
- Do not stop opiates in patients who are taking them regularly

PAIN

- Many opioid analgesics and their metabolites may accumulate in renal failure causing toxicity.
- To convert from other strong opioids to Alfentanil contact Palliative Care Team or Pharmacy for advice.

Contact NNUH Palliative Care Team 7 days / week 9-5 on DECT 7181/5052 or via Alertive

For out of hours advice contact the Palliative Care Advice Line 0330 158 8011 option 1

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Opioid Conversion Table
Opioid equivalent doses (Note: There is no exact equivalence between opioids therefore starting low and titrating upwards is recommended safe practice)
N.B. Please refer ALL patients on Methadone or Ketamine to the palliative care team for advice

Approximately equivalent opioid doses for PRN ('as required') use				
ORAL MORPHINE	**DIAMORPHINE INJECTION**	**MORPHINE INJECTION**	**ALFENTANIL INJECTION**	**OXYCODONE INJECTION**
4 milligrams orally	1.25 milligrams subcutaneously	2 milligrams subcutaneously	125 micrograms subcutaneously	1 milligram subcutaneously
8 milligrams orally	2.5 milligrams subcutaneously	4 milligrams subcutaneously	250 micrograms subcutaneously	2 milligrams subcutaneously
			Note: Alfentanil has a very short half-life and doses may only last 1-2 hours	

Note: Do not use these equivalent doses for larger doses without specialist palliative advice, as the small numbers entailed have been rounded up

Approximately equivalent opioid doses for starting doses in continuous subcutaneous infusions

Starting doses should be based on prior opioid requirements, and titrated upwards according to the amount of subsequent PRN doses required *in addition* to the continuous infusion – there is no upper limit provided the pain is responding well to the opioid, and there are no symptoms or signs of adverse effects or toxicity.
Most patients with renal failure require only low doses – if the dose is escalating, advice should be sought from the Palliative Care Team

	DIAMORPHINE INJECTION	**MORPHINE INJECTION**	**ALFENTANIL INJECTION**	**OXYCODONE INJECTION**
	5-10 milligrams Do not use Diamorphine in continuous infusion because of the high risk of accumulation and adverse effects	8-16 milligrams Do not use Morphine in continuous infusion because of the high risk of accumulation and adverse effects	500 micrograms-1 milligram	4-8 milligrams

3.2. Terminal Restlessness and Agitation

Doses must be proportional to current benzodiazepine medication

For further advice please contact the Palliative Care Team or Pharmacy for advice

Contact NNUH Palliative Care Team 7 days / week 9-5 on DECT 7181/5052 or via Alertive
For out of hours advice contact the Palliative Care Advice Line 0330 158 8011 option 1

3.3. Respiratory Tract Secretions

- *Avoid using Hyoscine in patients with severe cardiac failure as this can increase arrhythmias.*
- *For patients with severe cardiac failure use Glycopyrronium Bromide 200 micrograms stat SC and 600 micrograms/24 hours in syringe driver if required*

For further advice please contact the Palliative Care Team or Pharmacy for advice

Contact NNUH Palliative Care Team 7 days / week 9-5 on DECT 7181/5052 or via Alertive

For out of hours advice contact the Palliative Care Advice Line 0330 158 8011 option 1

3.4. Nausea and Vomiting

Doses must be proportional to current anti-emetic medication

For further advice please contact the Palliative Care Team or Pharmacy for advice.

Contact NNUH Palliative Care Team 7 days / week 9-5 on DECT 7181/5052 or via Alertive
For out of hours advice contact the Palliative Care Advice Line 0330 158 8011 option 1

3.5. DYSPNOEA (Breathlessness)

Doses must be proportional to current opiate/ benzodiazepine medication

Caution

Many of the opioid analgesics and their metabolites may accumulate in renal failure causing toxicity and Alfentanil is therefore the opioid of choice at the end of life.

For further advice please contact the Palliative Care Team or Pharmacy for advice.

Contact NNUH Palliative Care Team 7 days / week 9-5 on DECT 7181/5052 or via Alertive
For out of hours advice contact the Palliative Care Advice Line 0330 158 8011 option 1

4. Related Documents

- Anticipatory Medications for End of Life Patients (Document ID: 9883)
- Individual Plan of Care for End of Life for Adults (Document ID: 14301)

5. References

- National Institute for Health and Care Excellence (NICE) (2015) *Care of Dying Adults in the Last Day of Life*. NG31. Available at: https://www.nice.org.uk/guidance/ng31 accessed 25/1/23
- Leadership Alliance for the Care of Dying People. "One Chance to get it Right" (2014) *One Chance to get it right (publishing.service.gov.uk) accessed 25/1/23
- Charlesworth, S. (Ed.). (2020). *Palliative Care Formulary* (7th ed.). Pharmaceutical Press.

6. Audit of the process

Compliance with the process will be monitored through the following:

Key elements	Process for Monitoring	By Whom (Individual / group /committee)	Responsible Governance Committee /dept	Frequency of monitoring
Appropriate opioid choice	Audit	Palliative care	SPC Clinical Governance	2 years
Appropriate anticipatory medication prescribing	Audit	Palliative care	SPC Clinical Governance	2 years
Safe and appropriate doses	Audit	Palliative care	SPC Clinical Governance	2 years
Appropriate commencement of syringe driver	Audit	Palliative care	SPC Clinical Governance	2 years

The audit results are to be discussed at relevant governance meetings to review the results and recommendations for further action. Then sent to the End-of-Life Steering Group and Patient Experience and Engagement Group who will ensure that the actions and recommendations are suitable and sufficient.

7. Equality Impact Assessment (EIA)

Type of function or policy	New/Existing (remove which does not apply)

Division	Medicine	**Department**	Palliative Care
Name of person completing form	Dr Fergus Maher	**Date**	25/1/23

Equality Area	**Potential Negative Impact**	**Impact Positive Impact**	**Which groups are affected**	**Full Impact Assessment Required YES/NO**
Race	none	none	none	NO
Pregnancy & Maternity	none	none	none	NO
Disability	none	none	none	NO
Religion and beliefs	none	none	none	NO
Sex	none	none	none	NO
Gender reassignment	none	none	none	NO
Sexual Orientation	none	none	none	NO
Age	none	none	none	NO
Marriage & Civil Partnership	none	none	none	NO
EDS2 – How does this change impact the Equality and Diversity Strategic plan (contact HR or see EDS2 plan)?	This guideline does not impact the Equality and Diversity Strategic plan			

- **A full assessment will only be required if: The impact is potentially discriminatory under the general equality duty**
- **Any groups of patients/staff/visitors or communities could be potentially disadvantaged by the policy or function/service**
- **The policy or function/service is assessed to be of high significance**

IF IN DOUBT A FULL IMPACT ASSESSMENT FORM IS REQUIRED

The review of the existing policy re-affirms the rights of all groups and clarifies the individual, managerial and organisational responsibilities in line with statutory and best practice guidance.