



A summary of prescribing recommendations from NICE guidance

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Care of dying adults in the last days of life

NICE NG31; 2015

This guideline includes recommendations intended to help healthcare professionals recognise when a person may be entering the last days of their life, or if they may be deteriorating, stabilising or improving even temporarily.

Individualised care – see [NICE guideline](#)

- ◆ Ensure shared decision-making can be supported by experienced staff at all times. Seek specialist advice if additional support is required.

General principles

- ◆ If it is thought that a person may be entering the last days of life, gather and document information on:
 - > the person's physiological, psychological, social and spiritual needs,
 - > current clinical signs and symptoms,
 - > medical history and clinical context, including underlying diagnoses,
 - > the person's goals and wishes, and the views of those important to the person about future care.
- ◆ Assess for changes in signs and symptoms and review any investigation results that may suggest a person is entering the last days of life. Changes include:
 - > signs such as agitation, Cheyne–Stokes breathing, deterioration in level of consciousness, mottled skin, noisy respiratory secretions and progressive weight loss,
 - > symptoms such as increasing fatigue and loss of appetite,
 - > functional observations such as changes in communication, deteriorating mobility or performance status, or social withdrawal.
- ◆ Be aware that improvement in signs and symptoms or functional observations could indicate that the person may be stabilising or recovering.
- ◆ Avoid undertaking investigations unlikely to affect care in the last few days of life unless there is a clinical need.
- ◆ Use knowledge gained from assessments and information from the multidisciplinary team, the person and those important to them, to help determine whether the person is nearing death, deteriorating, stable or improving.
- ◆ Monitor for further changes in the person at least every 24 hours and update the person's care plan.
- ◆ When there is a high level of uncertainty about whether a person is entering the last days of life, may be stabilising or if there is potential for even temporary recovery seek advice from more experienced colleagues.

Shared decision-making – see [NICE guideline](#)

Communication – see [NICE guideline](#)

- ◆ Healthcare professionals need to take into consideration the person's current mental capacity to communicate and actively participate in their end of life care.

Pharmacological interventions

- ◆ When it is recognised that a person may be entering the last days of life, review and discuss their current medicines. Stop any medicines that are not providing symptomatic benefit or may cause harm.
- ◆ When making decisions about symptom control in the last days of life:
 - > use the person's individualised care plan to help decide which medicines are clinically appropriate,
 - > discuss benefits and harms of any medicines offered.
- ◆ When considering medicines for symptom control, take into account:
 - > likely cause of the patient's symptom,
 - > the person's preferences and the benefits and harms of the medicine,
 - > individual or cultural views that might affect choice,
 - > other medicines being taken to manage symptoms,
 - > any risks of the medicine that could affect prescribing decisions e.g. prescribing cyclizine to manage nausea and vomiting may exacerbate heart failure.
- ◆ Decide on the most effective route and consider prescribing different routes for administering medicines tailored to the dying person's condition, their ability to swallow safely, take and tolerate oral medicines and their preferences.
- ◆ Avoid intramuscular injections; give either subcutaneous or intravenous injections.
- ◆ Consider using a syringe pump to deliver medicines for continuous symptom control if more than 2 or 3 doses of any 'as required' medicines have been given within 24 hours.
- ◆ For people starting new treatments start with the lowest effective dose and titrate as clinically indicated.
- ◆ Regularly reassess, at least daily, symptoms during treatment to inform appropriate titration of medicine.
- ◆ If symptoms do not improve promptly with treatment or if there are undesirable side effects, such as unwanted sedation, seek specialist palliative care advice.

Maintaining hydration – see [NICE guideline](#)

Care of dying adults in last days of life continued.....

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Symptom management

- ◆ Always consider non-pharmacological methods.

Managing pain

- ◆ Be aware that not all people experience pain in the last days of life. If pain is identified, manage promptly and effectively and treat any reversible causes e.g. urinary retention.
- ◆ Assess level of pain and all possible causes when making prescribing decisions.
- ◆ Follow the principles of pain management when caring for people in the last days of life, e.g. match the medicine to severity of pain and, if possible, use the person's preferences for how it is given.
- ◆ Use a validated behavioural pain assessment to inform pain management for a person who is unable to effectively explain that they are in pain e.g. someone with dementia or learning disabilities.

Managing breathlessness

- ◆ Identify and treat reversible causes of breathlessness e.g. pulmonary oedema or pleural effusion.
- ◆ **Do NOT** routinely start oxygen to manage breathlessness. Only offer oxygen therapy to people known or clinically suspected to have symptomatic hypoxaemia.
- ◆ Consider managing breathlessness with:
 - > an opioid **U OR**,
 - > a benzodiazepine **U OR**,
 - > a combination of an opioid **U** and benzodiazepine **U**.

Managing nausea and vomiting

- ◆ Assess for likely causes of nausea or vomiting such as:
 - > medicines that can contribute to nausea and vomiting,
 - > recent chemotherapy or radiotherapy,
 - > psychological causes,
 - > biochemical causes e.g. hypercalcaemia,
 - > raised intracranial pressure,
 - > gastrointestinal motility disorder, ileus or bowel obstruction.
- ◆ When choosing medicines to manage nausea and vomiting, discuss options with the person and those important to them and take into account:
 - > likely cause and if it is reversible,
 - > side effects, including sedation,
 - > other symptoms the person has, and the desired balancing of effects when managing other symptoms,
 - > compatibility and drug interactions with other medicines.
- ◆ For people in the last days of life with obstructive bowel disorders who have nausea or vomiting, consider:
 - > **First-line:** hyoscine butylbromide **U**.
- ◆ If symptoms do not improve within 24 hours of starting treatment with hyoscine butylbromide consider octreotide **U**.

Managing anxiety, delirium and agitation

- ◆ Explore possible causes of anxiety or delirium, with or without agitation. Be aware that agitation in isolation is sometimes associated with other unrelieved symptoms or bodily needs e.g. unrelieved pain or a full bladder or rectum.
- ◆ Treat any reversible causes such as psychological causes or certain metabolic disorders (e.g. renal failure or hyponatraemia).
- ◆ Consider a trial of a benzodiazepine to manage anxiety or agitation.
- ◆ Consider a trial of an antipsychotic medicine to manage delirium or agitation.
- ◆ If diagnosis is uncertain, if agitation or delirium does not respond to antipsychotic treatment or if treatment causes unwanted sedation, seek specialist advice.

Managing noisy respiratory secretions

- ◆ Assess for likely causes and establish whether the noise has an impact on the person or those important to them. Reassure them that, although the noise can be distressing, it is unlikely to cause discomfort. Be prepared to talk about any fears or concerns they may have.
- ◆ Consider a trial of medicine if respiratory noises are causing distress to the person. Tailor treatment to the person's individual needs or circumstances. Use one of the following:
 - > atropine **U OR**,
 - > glycopyrronium bromide **U OR**,
 - > hyoscine butylbromide **U OR**,
 - > hyoscine hydrobromide **U**.
- ◆ When giving medicine for noisy respiratory secretions:
 - > monitor for improvements, preferably every 4 hours, but at least every 12 hours,
 - > monitor regularly for side effects, particularly delirium, agitation or excessive sedation when using atropine or hyoscine hydrobromide,
 - > treat side effects, such as dry mouth, delirium or sedation.
- ◆ Consider changing or stopping medicines if:
 - > noisy respiratory secretions continue and are still causing distress after 12 hours (medicines may take up to 12 hours to become effective).
 - > unacceptable side effects, such as dry mouth, urinary retention, delirium, agitation and unwanted levels of sedation, persist.

Anticipatory prescribing

- ◆ Use an individualised approach to prescribing anticipatory medicines for people likely to need symptom control in the last days of life. Specify indications for use and dosage of any medicines prescribed.
- ◆ Assess what medicines the person might need to manage symptoms likely to occur. Discuss any prescribing needs with the person, those important to them and the multidisciplinary team.
- ◆ Ensure suitable anticipatory medicines and routes are prescribed as early as possible. Review as the person's needs change.
- ◆ When deciding which anticipatory medicines to offer take into account the:
 - > likelihood of specific symptoms occurring,
 - > benefits and harms of prescribing/not prescribing or administering/not administering medicines,
 - > possible risk of the person suddenly deteriorating e.g. catastrophic haemorrhage or seizures, for which urgent symptom control may be needed,
 - > place of care and time it would take to obtain medicines.
- ◆ Before anticipatory medicines are administered, review individual symptoms and adjust the individualised care plan and prescriptions as necessary.
- ◆ If anticipatory medicines are administered:
 - > monitor for benefits and any side effects at least daily, and give feedback to the lead healthcare professional.
 - > adjust the individualised care plan and prescription as necessary.

U Unlicensed indication.

Recommendations – wording used such as 'offer' and 'consider' denote the [strength of the recommendation](#).

Drug recommendations – the guideline assumes that prescribers will use a drug's [Summary of Product Characteristics \(SPC\)](#) to inform treatment decisions.