# Caring for the dying

## Palliative Care for GPs

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# Key areas to cover

- Definition of “End of Life”
- What the Macmillan nurses want you to know!
- Case studies
- Just-in-case drugs and syringe driver principles
- Where to get advice and information

# End of life or last days of life?

## According to the GMC in 2010:

- End of life = likely to die within the next 12 months.
- Includes patients whose death is imminent (expected within hours or days) and those with:

• Advanced, progressive, incurable conditions

• General frailty and co-existing conditions that mean they are expected to die within 12 months

• Existing conditions if they are at risk of dying from a sudden acute crisis in their condition

• Life-threatening acute conditions caused by sudden catastrophic events

# What did the Mac nurses say?

- “Have conversations about dying with the patient”
- “Explain the dying process”

# Explain the dying process

# What did the Mac nurses say?

- “Have conversations about dying with the patient”
- “Explain the dying process”
- **“Talk to families about eating and drinking”**
- **“Explain what DNACPR really means”**

# Misconceptions about resuscitation success rates

77 people asked to complete a survey

60- year-old patient with widespread cancer, who is in a hospice and has exhausted all chemotherapy options

- 50% of people believed that CPR would give at least a 30% chance of successfully resuscitating


- Sundar, Santhanam & Do, Josephine & O'Cathail, Micheal. (2014). Misconceptions about 'do-not-resuscitate (DNR)' orders in the era of social media. Resuscitation. 86. 10.1016/j.resuscitation.2014.10.014.

# Misconceptions about resuscitation success rates

77 people asked to complete a survey

80-year-old with severe pneumonia who has collapsed in nursing home

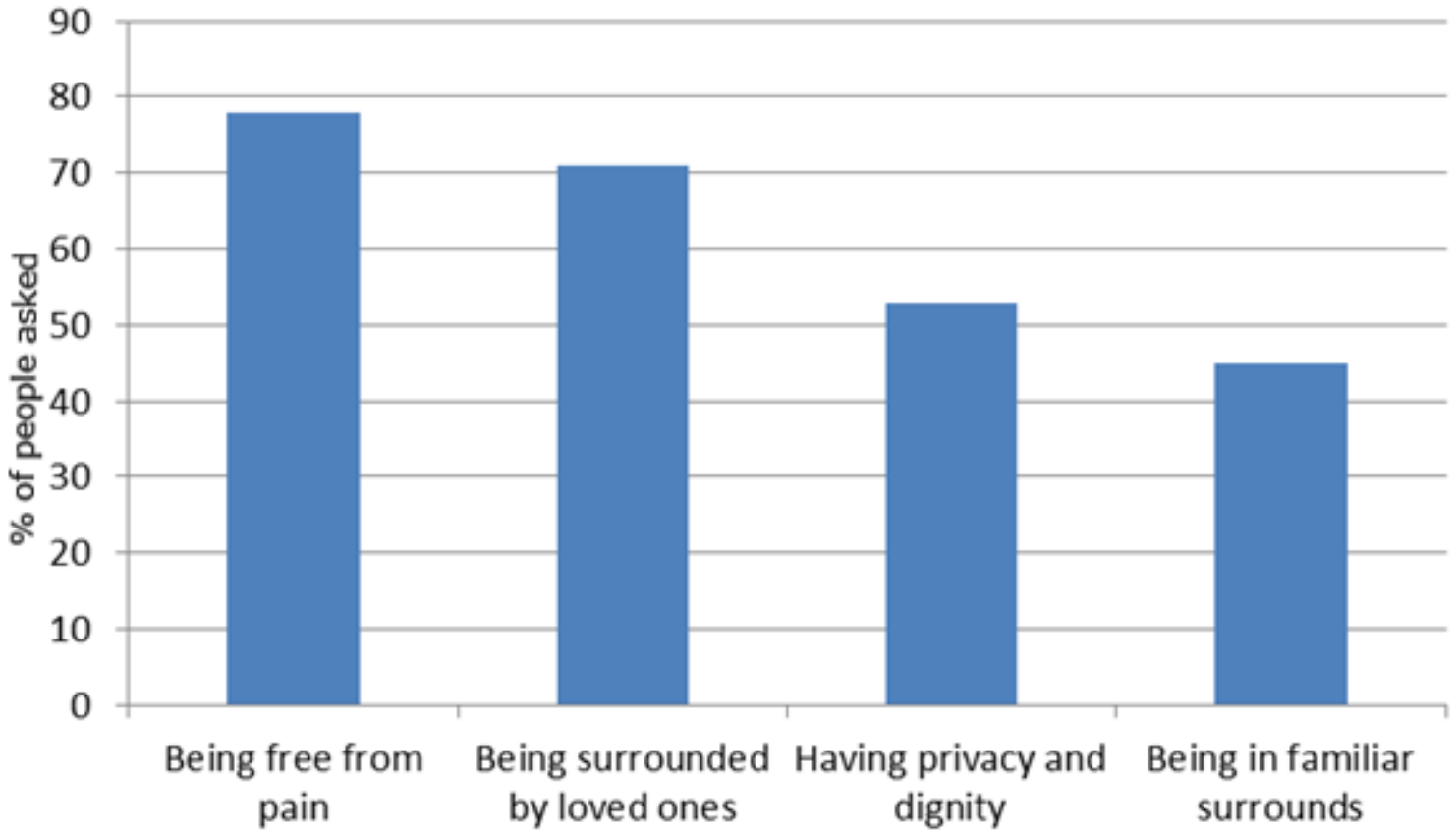
- 38% of people believed CPR has at least 30% chance of success


- Sundar, Santhanam & Do, Josephine & O'Cathail, Micheal. (2014). Misconceptions about 'do-not-resuscitate (DNR)' orders in the era of social media. Resuscitation. 86. 10.1016/j.resuscitation.2014.10.014.

# What did the Mac nurses say?

- “Have conversations about dying with the patient”
- “Explain the dying process”
- “Talk to families about eating and drinking”
- “Explain what DNACPR really means”
- **“Prescribe oramorph and lorazepam with shorter intervals”**

# Getting symptom control right



# e-ELCA – online learning about pall care

"The ability to enable patients to **die in comfort**, **without troubling symptoms**, is an **essential** skill for nurses and doctors.

To be able to help achieve a **peaceful, dignified death**, when others have said there's nothing more we can do...

...can be one of the most **satisfying and rewarding** parts of being a nurse or doctor."

# Symptom Control - pain

- **40-99% of dying patients experience pain**
  - Underlying condition
  - Bedbound
  - Can't take/absorb their oral pain killers.
- Most important aspect of dying well? **Pain control**

# Symptom control - breathlessness

- 50-80% of dying patients experience breathlessness
- There are many different causes
  - Fatigue
  - Positional
  - Anxiety
  - Infection
  - Pulmonary oedema

# Symptom control – N&V

- 70% of dying patients experience nausea and/or vomiting
  - Metabolic
  - Drug toxicities
  - Bowel obstruction
  - Gut oedema due to right sided heart failure
  - Unable to take oral anti-emetics
  - Anxiety

# Symptom control - restlessness and agitation

- 80% of dying patients experience delirium, restlessness and terminal agitation
  - Uncontrolled fear
  - Anxiety, psychological or spiritual distress
  - Pain
  - Metabolic abnormalities
  - Medication toxicities
  - Thirst
  - Faecal impaction
  - Urinary retention or incontinence

# Symptom control - Respiratory secretions

- Up to 90% of patients have audible secretions in the last day or two of life
  - Usually when the patient is semi-conscious or unconscious - no longer able to clear oropharyngeal secretions
  - Not distressing for the patient but it may be distressing for their relatives to hear

# Anticipatory prescribing

- Ensure patient has injectable meds for top 4 symptoms
- Tailor opioids and antiemetics to the patient
- Modify in renal impairment
- Ensure the drugs and community prescription are both in the house

# Case study 1 - Ryan

- Home visit – 43 year old known metastatic colorectal cancer
- Extremely drowsy, but clearly uncomfortable – moaning and grimacing
- His family say he was complaining of an ache in his back a couple of days ago - paracetamol didn't help
- His catheter is draining and he opened his bowels yesterday
- What should you prescribe?

# Thought process

- Strong opioid – which route?
- Drowsy so SC. PRN or regular?
- PRN first as opioid naïve. Which opioid?
- No known renal impairment or allergies, so morphine. Dose?
- 2.5 to 5mg 2 hourly
- Anything else? Consider an anti-emetic, a sedative and ? a laxative if not imminently dying. Check DNs happy with the plan, and review to consider CSCI

| Patient Name | Allergies / Sensitivities (or state if none known) | Chart.....1.....of.....1..... |
|---|---|---|
| MR RYAN REYNOLDS<br>Date of birth<br>Address | NKDA | |

**Adult Anticipatory Medication Chart - For as required use**

| Suggested indication | Medicine | Dose or range | Frequency | Route | Maximum prn dose in 24 hours (including pump if appropriate) | Additional Instructions / indications for use | Prescriber's Signature | Print Name | Date |
|---|---|---|---|---|---|---|---|---|---|
| PAIN | MORPHINE | 2.5-5mg | 2 HOURLY | SC | | | R Marvin | R MARVIN | 4/11/19 |
| ANXIETY AGITATION | MIDAZOLAM | 2.5-5mg | 2 HOURLY | SC | | | R Marvin | R MARVIN | 4/11/19 |
| RESPIRATORY SECRETIONS | GLYCOPYRRONIUM | 0.2mg | 6 HOURLY | SC | | | R Marvin | R MARVIN | 4/11/19 |
| NAUSEA VOMITING | CYCLIZINE | 50mg | 8 HOURLY | SC | | | R Marvin | R MARVIN | 4/11/19 |
| OTHER | | | | | | | | | |
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Medication authorised in hospital/hospice are valid for maximum of two weeks. For continual use chart must be reviewed within 2 weeks or sooner Valid until date after 1st authorisation: .....

Prescriber/authoriser contact number ..... Prescriber/authoriser employing organisation ..... Hospital/hospice pharmacy validation .....

**Administration Record – see page 6 for further space**

| Date | Time | Medicine | Dose | Route | Site | B/N & Expiry Date | Reason/ Symptom | Sign | Print |
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# Case study 2 - Emma

- 46-year-old lady with metastatic breast cancer, who is dying
- Nurses are concerned because Emma has been unable to take her regular morphine tablets
- You assess Emma- she is comfortable
- Pain from her liver metastases has been well controlled on modified release morphine 30mg 12 hourly
- However, since early evening Emma has become more sleepy and is struggling to wake to take her medication

How much morphine should go in her syringe driver (continuous subcutaneous infusion, CSCI)?

| Patient Name<br>MRS EMMA STONE<br>Date of birth<br>Address | Allergies / Sensitivities (or state if none known)<br>NKDA<br><br>Opioid patch in situ: ☐ Yes ☐ No<br>State drug and strength: | Chart.....1.....of.....1.....<br>**Number of syringe pump charts in use**<br>(If 2 syringe pumps are in use, use a separate chart for each one and cross reference) |
|---|---|---|

| **Continuous Subcutaneous Syringe Pump Medication Chart** | | |
|---|---|---|
| Medicine (Only administer if symptoms dictate) | | Dose / Range over 24 hours |
| Medicine A MORPHINE | | 30mg |
| ~~Medicine B~~ | | |
| ~~Medicine C~~ | | |
| ~~Medicine D~~ | | |
| Diluent ~~Water for Injection /~~ Sodium Chloride 0.9% Injection (delete) | Route **SC** | Additional instructions |
| Cross through any blank lines A to D to prevent changes to medication chart after signing.<br>**If a change to the medicines / doses is required rewrite in a new medication chart.** | | |
| Authorisers/Prescribers signature *R Marvin* | Print Name R MARVIN | |
| Date (DD/MM/YY) 4/11/19 | Valid until (DD/MM/YY) | |

| **Administration Record Week 1** Syringe pump serial number: 1..... 2..... | | | | | | | |
|---|---|---|---|---|---|---|---|
| Date | | | | | | | |
| Start time | | | | | | | |
| Dose of A | | | | | | | |
| Dose of B | | | | | | | |
| Dose of C | | | | | | | |
| Dose of D | | | | | | | |
| Total volume in syringe (ml) | | | | | | | |
| Syringe size | | | | | | | |
| Line primed Y / N | | | | | | | |
| Rate displayed (ml / hr) | | | | | | | |
| Battery % | | | | | | | |
| Site check (tick) | | | | | | | |
| Sign / Print | | | | | | | |

**Medication authorised in hospital/hospice are valid for maximum of two weeks. For continual use, chart must be reviewed.**

| | Administration Record: Week 2 | | | | | | | Administration Record: Week 3 | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Date | | | | | | | | | | | | | | |
| Start time | | | | | | | | | | | | | | |
| Dose of A | | | | | | | | | | | | | | |
| Dose of B | | | | | | | | | | | | | | |
| Dose of C | | | | | | | | | | | | | | |
| Dose of D | | | | | | | | | | | | | | |
| Total volume in Syringe (ml) | | | | | | | | | | | | | | |
| Syringe size | | | | | | | | | | | | | | |
| Line primed Y/N | | | | | | | | | | | | | | |
| Rate displayed (ml/hr) | | | | | | | | | | | | | | |
| Battery % | | | | | | | | | | | | | | |
| Site check (tick) | | | | | | | | | | | | | | |
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# Which PRN to prescribe alongside 30mg morphine/24h?

- **A.** Morphine 1-2mg SC PRN 1 hourly for pain
- B. Morphine 5mg SC PRN 2 hourly for pain
- **C.** Morphine 2.5-5mg SC PRN 6 hourly for pain
- **D.** Morphine 30mg SC PRN 8 hourly for pain

| Patient Name | Allergies / Sensitivities (or state if none known) | Chart.....1.....of.....1..... |
|---|---|---|
| MRS EMMA STONE<br>Date of birth<br>Address | NKDA | |

**Adult Anticipatory Medication Chart - For as required use**

| Suggested indication | Medicine | Dose or range | Frequency | Route | Maximum prn dose in 24 hours (including pump if appropriate) | Additional Instructions / indications for use | Prescriber's Signature | Print Name | Date |
|---|---|---|---|---|---|---|---|---|---|
| PAIN | MORPHINE | 5mg | 2 HOURLY | SC | | | R Marvin | R MARVIN | 4/11/19 |
| ANXIETY AGITATION | MIDAZOLAM | 2.5-5mg | 2 HOURLY | SC | | | R Marvin | R MARVIN | 4/11/19 |
| RESPIRATORY SECRETIONS | GLYCOPYRRONIUM | 0.2mg | 6 HOURLY | SC | | | R Marvin | R MARVIN | 4/11/19 |
| NAUSEA VOMITING | CYCLIZINE | 50mg | 8 HOURLY | SC | | | R Marvin | R MARVIN | 4/11/19 |
| OTHER | | | | | | | | | |
| OTHER | | | | | | | | | |
| OTHER | | | | | | | | | |

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Prescriber/authoriser contact number ..... Prescriber/authoriser employing organisation ..... Hospital/hospice pharmacy validation .....

**Administration Record – see page 6 for further space**

| Date | Time | Medicine | Dose | Route | Site | B/N & Expiry Date | Reason/ Symptom | Sign | Print |
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# What happens next

- You are asked to review Emma 4 hours later. You arrive to find her crying in pain. What should you do?
- **Reassess** - New pain could have developed, e.g. as a result of urinary retention.
- **Refer to SPC** - Palliative Care Teams are experienced in dealing with these situations. The pain may have psychological or spiritual aspects to it which need addressing. They may not always be able to see the patient immediately, but there should always be someone available by phone to give advice to the frontline professionals. Sometimes this is from the local hospice.

# Case study 3 - Patrick

- Joy is a district nurse and has been called by Jack who is anxious about his partner, Robert.

  Robert has severe COPD and is now dying. He wants to remain at home, but his breathing is really frightening him.

  What should Joy do?
- Sit Robert up - Repositioning can make the work of breathing easier
- Place a fan near Patrick and open a window - The movement of air across the face can help the feeling of breathlessness
- Determine whether there are any medications for terminal breathlessness already in the house
- Medications such as morphine and midazolam are useful in this situation
- Arrange for hospital admission?

| Patient Name<br><br>Date of birth<br>Address | Allergies / Sensitivities (or state if none known) | Chart.....1.....of.....1..... |
|---|---|---|
| ROBERT DE NIRO | NKDA | |

**Adult Anticipatory Medication Chart - For as required use**

| Suggested indication | Medicine | Dose or range | Frequency | Route | Maximum prn dose in 24 hours (including pump if appropriate) | Additional Instructions / indications for use | Prescriber's Signature | Print Name | Date |
|---|---|---|---|---|---|---|---|---|---|
| PAIN | MORPHINE | 2.5-5mg | 2 hourly | SC | | | R Marvin | R MARVIN | 4/11/19 |
| ANXIETY AGITATION | MIDAZOLAM | 2.5-5mg | 2 hourly | SC | | | R Marvin | R MARVIN | 4/11/19 |
| RESPIRATORY SECRETIONS | GLYCOPYRRONIUM | 0.2mg | 6 hourly | SC | | | R Marvin | R MARVIN | 4/11/19 |
| NAUSEA VOMITING | CYCLIZINE | 50mg | 8 hourly | SC | | | R Marvin | R MARVIN | 4/11/19 |
| OTHER | | | | | | | | | |
| OTHER | | | | | | | | | |
| OTHER | | | | | | | | | |

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**Administration Record – see page 6 for further space**

| Date | Time | Medicine | Dose | Route | Site | B/N & Expiry Date | Reason/ Symptom | Sign | Print |
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# What happens next

- Jack calls his friend to collect the prescription and take it to the chemist. He arrives back with the medication 2 hours later, by which time Robert is very breathless again. Joy gives 2.5mg of morphine SC which really helps Robert to feel less breathless.

- Jack needs to call the district nurses back during the night as Robert becomes breathless again. They give him another dose of morphine 2.5mg which is effective at easing his breathlessness. Robert dies the following day.

# Case study 4 - Olivia

- You have been asked by the district nurses to review Olivia, who is dying from metastatic bowel cancer.

- Olivia is feeling nauseated and has vomited several times. Her nausea was previously controlled by oral cyclizine 50mg TDS, but she is now vomiting up her medications.

- You assess Olivia. She has advanced colorectal cancer, with liver and brain metastases. She is fatigued and bed bound. She has recently been started on morphine MR 10mg 12 hourly for her pain. She has not opened her bowels for 4 days.

- What could be causing her N&V?

# Possible reasons for Olivia's nausea and vomiting include:

- Gastric stasis due to drugs such as opioids
- Squashed stomach syndrome due to tumour or enlarged liver or ascites, or due to outflow obstruction by tumour
- Constipation
- Chemically induced nausea due to drugs, such as morphine and antibiotics, or metabolic causes such as renal or hepatic failure, hypercalcaemia, hyponatraemia or ketoacidosis
- Raised intracranial pressure due to brain metastases

What should you do?

# What should you do?

- **A.** Continue cyclizine and add in oral metoclopramide 10mg TDS
- **B.** Insert a nasogastric (NG) tube
- **C.** Arrange for a CT scan of Olivia's abdomen
- **D.** Start a syringe driver of cyclizine 150mg/ 24 hours
- **E.** Completely stop her morphine medication

# What happens next

- You prescribe a syringe driver containing 150mg cyclizine and 10mg morphine over 24 hours
- You also prescribe haloperidol 0.5-1mg SC up to 6 hourly in case Olivia's nausea and vomiting does not respond well enough to the cyclizine.
- You return later to find her comfortable - she no longer feels sick and has not had any more episodes of vomiting.
- She dies later that night.

| Patient Name | Allergies / Sensitivities (or state if none known) | Chart.....1.....of.....1..... |
|---|---|---|
| Date of birth<br>Address<br>OLIVIA COLEMAN | NKDA | **Number of syringe pump charts in use**<br>(If 2 syringe pumps are in use, use a separate chart for each one and cross reference) |

Opioid patch in situ: ☐ Yes ☐ No
State drug and strength:

**Continuous Subcutaneous Syringe Pump Medication Chart**

| Medicine (Only administer if symptoms dictate) | | Dose / Range over 24 hours |
|---|---|---|
| Medicine A | MORPHINE | 10mg |
| Medicine B | CYCLIZINE | 150mg |
| Medicine C | | |
| Medicine D | | |
| Diluent: Water for Injection / Sodium Chloride 0.9% Injection (delete) | Route **SC** | Additional instructions |

Cross through any blank lines A to D to prevent changes to medication chart after signing.
**If a change to the medicines / doses is required rewrite in a new medication chart.**

| Authorisers/Prescribers signature | Print Name |
|---|---|
| *R Marvin* | R MARVIN |
| Date (DD/MM/YY) 4/11/19 | Valid until (DD/MM/YY) |

**Administration Record Week 1** Syringe pump serial number: 1..... 2.....

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Date | | | | | | | |
| Start time | | | | | | | |
| Dose of A | | | | | | | |
| Dose of B | | | | | | | |
| Dose of C | | | | | | | |
| Dose of D | | | | | | | |
| Total volume in syringe (ml) | | | | | | | |
| Syringe size | | | | | | | |
| Line primed Y / N | | | | | | | |
| Rate displayed (ml / hr) | | | | | | | |
| Battery % | | | | | | | |
| Site check (tick) | | | | | | | |
| Sign / Print | | | | | | | |

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| | Administration Record: Week 2 | | | | | | | Administration Record: Week 3 | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Date | | | | | | | | | | | | | | |
| Start time | | | | | | | | | | | | | | |
| Dose of A | | | | | | | | | | | | | | |
| Dose of B | | | | | | | | | | | | | | |
| Dose of C | | | | | | | | | | | | | | |
| Dose of D | | | | | | | | | | | | | | |
| Total volume in Syringe (ml) | | | | | | | | | | | | | | |
| Syringe size | | | | | | | | | | | | | | |
| Line primed Y/N | | | | | | | | | | | | | | |
| Rate displayed (ml/hr) | | | | | | | | | | | | | | |
| Battery % | | | | | | | | | | | | | | |
| Site check (tick) | | | | | | | | | | | | | | |
| Sign / print | | | | | | | | | | | | | | |

# Case study 5 - Ian

- George is a nurse in a care home. He is looking after Ian, an 80-year-old gentleman who is dying from end stage dementia. Ian is barely conscious but his breathing has become very noisy.

- His brother is distressed by this and tells George that he thinks Ian is drowning.

- George phones you for advice

What do you do?

# What advice can you give?

- This is clearly really upsetting for the family, but Ian is not aware and does not appear distressed

- If you explain why this is happening maybe that will reassure them
- Try to sit Ian up, or put him on his side, this might help to reduce the noise
- Gentle suctioning of secretions in the mouth may help

- If these measures don't work, you could try an injection of glycopyrronium which was prescribed in anticipation of this symptom developing

| Patient Name | Allergies / Sensitivities (or state if none known) | Chart.....1.....of.....1..... |
|---|---|---|
| Date of birth IAN MCKELLAN<br>Address | NKDA | . |

**Adult Anticipatory Medication Chart - For as required use**

| Suggested indication | Medicine | Dose or range | Frequency | Route | Maximum prn dose in 24 hours (including pump if appropriate) | Additional Instructions / indications for use | Prescriber's Signature | Print Name | Date |
|---|---|---|---|---|---|---|---|---|---|
| PAIN | MORPHINE | 2.5-5mg | 2 hourly | SC | | | R Marvin | R MARVIN | 4/11/19 |
| ANXIETY AGITATION | MIDAZOLAM | 2.5-5mg | 2 hourly | SC | | | R Marvin | R MARVIN | 4/11/19 |
| RESPIRATORY SECRETIONS | GLYCOPYRRONIUM | 0.2mg | 6 hourly | SC | | | R Marvin | R MARVIN | 4/11/19 |
| NAUSEA VOMITING | CYCLIZINE | 50mg | 8 hourly | SC | | | R Marvin | R MARVIN | 4/11/19 |
| OTHER | | | | | | | | | |
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| OTHER | | | | | | | | | |

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**Administration Record – see page 6 for further space**

| Date | Time | Medicine | Dose | Route | Site | B/N & Expiry Date | Reason/ Symptom | Sign | Print |
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# What happens next

- George gently repositions Ian, sitting him up. George reassures Ian's brother and family. Ian's breathing sounds less gurgly and he does not require suctioning.

- Ian dies peacefully a few hours later.

# Just in case - principles

- Anticipatory prescribing is designed to enable prompt symptom relief at whatever time the patient develops distressing symptoms
- Palliative care is traditionally thought of as being a part of cancer care, but many life-limiting illnesses such as cardiac, neurological and respiratory diseases can benefit from this approach.
- You as the prescriber are responsible
- Good time to explore with the patient and family the prognosis, and to ensure they understand how to access care appropriately in the event of deterioration

# Just in case choices

- Prescription should be based on the individual patient's underlying condition
- The choice of anti-emetic depends on the potential cause of any nausea and vomiting
- The choice of opiate may be altered depending on prior pain relief and renal function

# Analgesia calculations

- Use starting dose on Pan-Hertfordshire chart if opioid naïve

- Use Oxycodone if renal impairment

- If already on oral opioids and need to start CSCI:

1. Add up total opioid use over 24 hours inc. regular and PRN
2. Use conversion chart to convert total to oral morphine equivalent
3. Use conversion chart to convert this total to a 24h SC dose as well as PRN dose

# Example

- Jenny is taking 60mg BD of MST for abdominal pain due to metastatic ovarian cancer. She is drowsy and struggling to swallow tablets.
- In the past 24 hours, she has used 4 doses of oramorph 20mg
- Total in 24 hours = 60 X 2 + 4 X 20 = 200mg oral morphine
- Convert to SC morphine 200 ÷ 2 = 100mg morphine in CSCI
- Calculate PRN dose 100 ÷ 6 = 16.666…mg SC PRN
- Sensible PRN dose required – 15-20mg SC PRN 2 hourly

# What if already on a patch?

- If a CSCI is required and the patient is already on a patch

  DO NOT STOP THE PATCH

- Calculate patch dose in oral morphine equivalent

- Add up PRN doses over past 24 hours and convert to oral morphine equivalent

- Put equivalent of PRN doses in CSCI, and recalculate PRN as SC

# Example

- Rose is on a 25mcg/hour fentanyl patch for pain due to spinal mets

- She has used 4 doses of PRN oral morphine 15mg in the past 24 hours

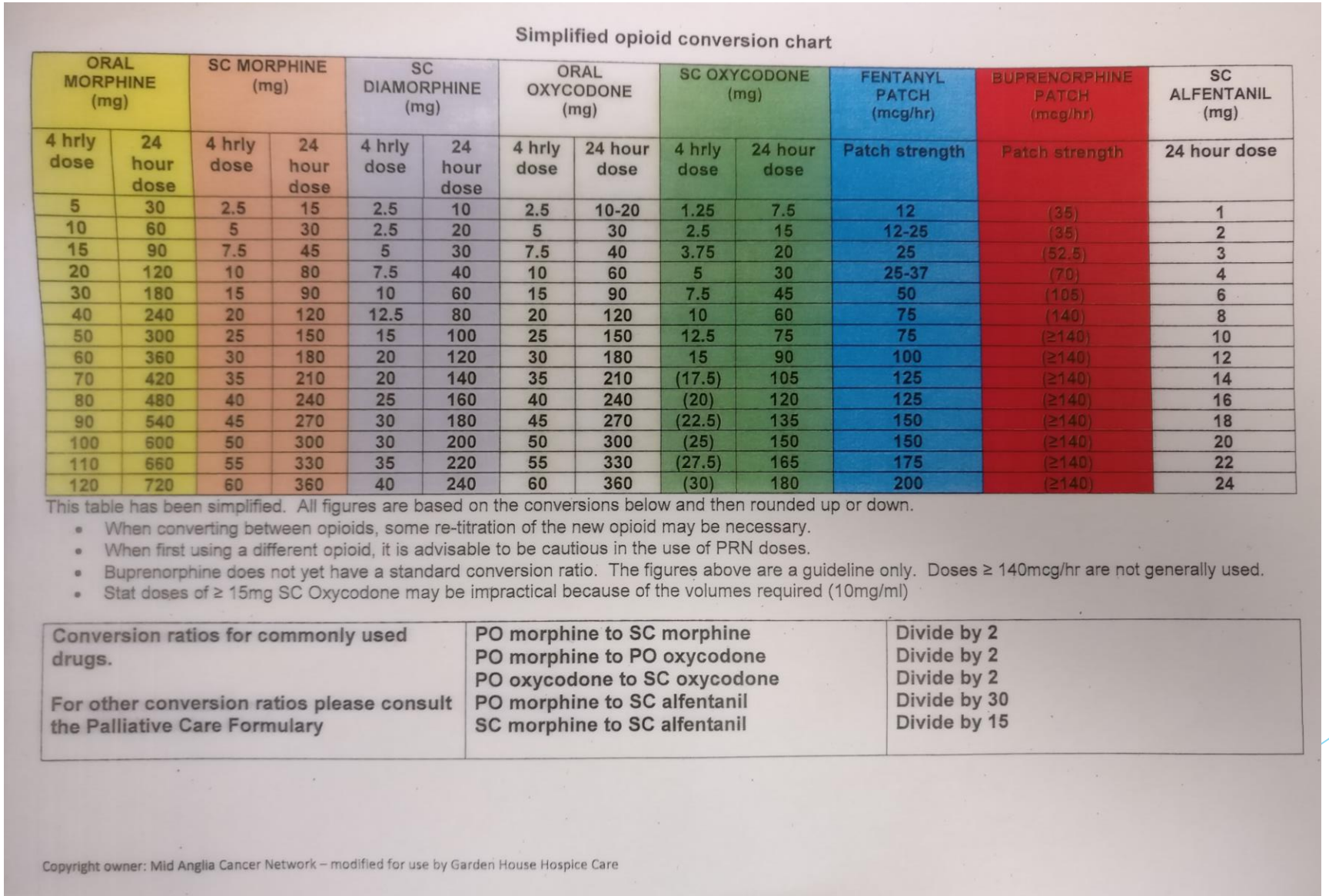
  = 60mg oral morphine

- Convert her total 24 hour use of oral morphine to SC dose –

  60mg ÷ 2 = 30mg SC morphine in CSCI **IN ADDITION TO HER PATCH**

- Then recalculate her new PRN dose as 1/6$^{th}$ of total (patch and CSCI):
- 25mcg/hr fentanyl = between 60-90mg oral morphine/24 hours
- Total in 24h is ~ 120mg oral morphine so PRN dose is 1/6$^{th}$ = 20mg oral morphine or 10mg SC morphine

# Conversion charts are your friend



Simplified opioid conversion chart

| ORAL MORPHINE (mg) | | SC MORPHINE (mg) | | SC DIAMORPHINE (mg) | | ORAL OXYCODONE (mg) | | SC OXYCODONE (mg) | | FENTANYL PATCH (mcg/hr) | BUPRENORPHINE PATCH (mcg/hr) | SC ALFENTANIL (mg) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4 hrly dose | 24 hour dose | 4 hrly dose | 24 hour dose | 4 hrly dose | 24 hour dose | 4 hrly dose | 24 hour dose | 4 hrly dose | 24 hour dose | Patch strength | Patch strength | 24 hour dose |
| 5 | 30 | 2.5 | 15 | 2.5 | 10 | 2.5 | 10-20 | 1.25 | 7.5 | 12 | (35) | 1 |
| 10 | 60 | 5 | 30 | 2.5 | 20 | 5 | 30 | 2.5 | 15 | 12-25 | (35) | 2 |
| 15 | 90 | 7.5 | 45 | 5 | 30 | 7.5 | 40 | 3.75 | 20 | 25 | (52.5) | 3 |
| 20 | 120 | 10 | 80 | 7.5 | 40 | 10 | 60 | 5 | 30 | 25-37 | (70) | 4 |
| 30 | 180 | 15 | 90 | 10 | 60 | 15 | 90 | 7.5 | 45 | 50 | (105) | 6 |
| 40 | 240 | 20 | 120 | 12.5 | 80 | 20 | 120 | 10 | 60 | 75 | (140) | 8 |
| 50 | 300 | 25 | 150 | 15 | 100 | 25 | 150 | 12.5 | 75 | 75 | (≥140) | 10 |
| 60 | 360 | 30 | 180 | 20 | 120 | 30 | 180 | 15 | 90 | 100 | (≥140) | 12 |
| 70 | 420 | 35 | 210 | 20 | 140 | 35 | 210 | (17.5) | 105 | 125 | (≥140) | 14 |
| 80 | 480 | 40 | 240 | 25 | 160 | 40 | 240 | (20) | 120 | 125 | (≥140) | 16 |
| 90 | 540 | 45 | 270 | 30 | 180 | 45 | 270 | (22.5) | 135 | 150 | (≥140) | 18 |
| 100 | 600 | 50 | 300 | 30 | 200 | 50 | 300 | (25) | 150 | 150 | (≥140) | 20 |
| 110 | 660 | 55 | 330 | 35 | 220 | 55 | 330 | (27.5) | 165 | 175 | (≥140) | 22 |
| 120 | 720 | 60 | 360 | 40 | 240 | 60 | 360 | (30) | 180 | 200 | (≥140) | 24 |

This table has been simplified. All figures are based on the conversions below and then rounded up or down.

- When converting between opioids, some re-titration of the new opioid may be necessary.
- When first using a different opioid, it is advisable to be cautious in the use of PRN doses.
- Buprenorphine does not yet have a standard conversion ratio. The figures above are a guideline only. Doses ≥ 140mcg/hr are not generally used.
- Stat doses of ≥ 15mg SC Oxycodone may be impractical because of the volumes required (10mg/ml)

| | | |
|---|---|---|
| **Conversion ratios for commonly used drugs.** | **PO morphine to SC morphine** | **Divide by 2** |
| | **PO morphine to PO oxycodone** | **Divide by 2** |
| | **PO oxycodone to SC oxycodone** | **Divide by 2** |
| **For other conversion ratios please consult the Palliative Care Formulary** | **PO morphine to SC alfentanil** | **Divide by 30** |
| | **SC morphine to SC alfentanil** | **Divide by 15** |

# Where to get help

- Garden House Hospice– call 24/7 for advice 01462 416794
- Hospice website – referrals https://www.ghhospicecare.org.uk/professionals/how-to-refer
- Palliative Care Adult Network Guidelines http://book.pallcare.info/index.php

This is a huge resource with an opioid conversion calculator, advice on symptom control, info on psychological and spiritual support, CSCI drug compatibility and more

- To learn more – e-ELCA (part of eLFH) – get some CPD

# Remember palliative care teams are here to help