Waterloo Wellington (WW) Symptom Management Guideline for the End of Life (EOL) Medication Order Set for Long Term Care (LTC)

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THE WATERLOO WELLINGTON SYMPTOM MANAGEMENT GUIDELINE FOR THE END OF LIFE MEDICATION ORDER SET FOR LONG TERM CARE

The Waterloo Wellington (WW) Symptom Management Guideline for the End of Life (EOL) Medication Order Set for Long Term Care (LTC) is a consensus based, evidence informed guideline to provide care and symptom management at end-of-life. It is the responsibility of each member of the health care team working in collaboration with the Resident and their family to manage symptoms based on the Residents' goals of care**.** The Resident's self-report is the primary source for information about symptoms. Family or healthcare provider reports are included for those unable to give self-report.

Most of the Residents we care for will die from complications of progressive chronic and/or advanced disease. It is difficult to accurately predict the rate at which a Resident's condition will deteriorate or when they will die.

Use of the WW Symptom Management Guideline for the EOL Medication Order Set for LTC to manage the symptoms associated with end of life clinical situations aims to improve the quality of dying for the Resident and the family. Common end-of-life symptom management medications will be ordered or found stocked in emergency boxes to manage Residents' symptoms.

Inclusion Criteria:

All Residents with a life limiting condition identified by the clinical team as having a change in condition that suggests they may be approaching and are suffering symptoms suggestive of end-of-life (consider Residents with or Palliative Performance Scale (PPS) of 30% or lower, Residents with 2 or more general indicators of decline per the WW IHPC Early Identification & Prognostic Indicator Guide etc.)

STANDARD:

1. Residents' symptoms will be managed in a timely fashion at end of life, following symptom management guidelines which are based on best practice.

GOALS:

1. Symptom management for Residents requiring a palliative approach to care at end-of-life to optimize comfort and function in the face of inevitable deterioration.
2. To effectively achieve symptom management by incorporating pharmacological and non-pharmacological interventions into individualized treatment plans.

PROCEDURES:

1. All staff will identify end of life symptoms (see APPENDIX 2) and report them to a registered staff member (or Supervisor). Registered staff will then coordinate care (see APPENDIX 3).
2. Registered staff will notify appropriate physician/ nurse practitioner of Resident's change in status and development of end of life symptoms. Obtain Resident specific orders (see APPENDIX 1).
3. Implement orders, assess and document effectiveness.
4. Allow pharmacy to stock the medications ordered during normal business hours. Use the medication in the Emergency box if the pharmacy is closed or there is too long a wait for the medications (e.g. the Resident is in severe distress). Consider the home's policy for Emergency drug use.

5. The WW EOL Medication Order Set is in effect for a three-month period. The WW EOL Medication Order Set must be reviewed and resigned if required beyond a three-month period.

DOCUMENT:

- Reason for the call and orders received from the physician/ nurse practitioner.
- Nursing assessment and Resident response in multidisciplinary notes as required.
- Medications as required on the medication administration record (MAR).

REVISED IN CONSULTATION WITH:

- Waterloo Wellington EOL Medication Order Set for LTC Regional Task Force
- WW LHIN

Appendix 1: The WW EOL Medication Order Set for LTC

Resident Name: DOB: Date:		Allergy:		Logo
Medication	Symptom/ Order	Quantity to be dispensed	Send now Yes/ No	Prescriber Authorization
Morphine 5 mg tablet	**Pain or Dyspnea:** 2.5 mg (1/2 tab) po q4h and 2.5 mg (1/2 tab) q1h prn	10 x ½ tablet	□ Yes □ No	
Morphine 10 mg/mL **LU Code: 481**	**Pain or Dyspnea:** 1 mg (0.1 mL) subcut q4h and 1 mg (0.1 mL) subcut q30min prn	5 x 1 mL amp	□ Yes □ No	
HYDROmorphone 1 mg tablet	**Pain or Dyspnea:** 0.5 mg (1/2 tab) po q4h and 0.5 mg (1/2 tab) po q1h prn	10 x ½ tablet	□ Yes □ No	
HYDROmorphone 2 mg/mL	**Pain or Dyspnea:** 0.25 mg (0.125 mL) subcut q4h and 0.25 mg (0.125 mL) subcut q30min prn	5 x 1 mL amp	□ Yes □ No	
Specific order if opioid tolerant □**Morphine** □**HYDROmorphone**	**Pain or Dyspnea:**		□ Yes □ No	
MIDazolam 5 mg/mL **LU Code: 495**	**Seizure:** 5 mg (1 mL) subcut stat and repeat every 10 minutes to a total of 3 times	5 x 1mL amp	□ Yes □ No	
MIDazolam 5 mg/mL **LU Code: 495**	**Severe Restlessness/ Delirium:** 1 to 5 mg subcut q30min prn if sedation is the primary goal and/or other treatments have failed.	5 x 1mL amp	□ Yes □ No	
Haloperidol 5 mg/mL	**Restlessness/ Nausea:** 0.5 to 1.0 mg (0.1 to 0.2 mL) subcut q4h prn	5 x 1 mL amp	□ Yes □ No	
Methotrimeprazine 25 mg/mL	**Restlessness/Delirium:** 2.5 to 5 mg po/subcut (0.1 to 0.2 mL) q1h prn plus or minus (±) 2.5 to 5 mg po/subcut (0.1 to 0.2 mL) daily or bid	5 x 1 mL amp	□ Yes □ No	
Scopolamine 0.4 mg/mL **LU Code: 481**	**Terminal Secretions:** 0.4 mg (1 mL) subcut q4h prn	5 x 1 mL amp	□ Yes □ No	
Dexamethasone 4 mg/mL	**For Escalating Pain:** 4 mg (1 mL) subcut daily	1 x 5 mL amp	□ Yes □ No	
	Urinary retention Foley Catheter prn			

Reference Tool for WW EOL Medication Order Set for LTC
Notify the Physician/ Nurse Practitioner if any of these symptoms develop.
Obtain specific orders for each Resident.

These guidelines are based on best practice evidence and are intended to support, not replace, clinical judgement. If you have any concerns regarding administering any of the medications, please contact your Supervisor.

Symptom	Pharmacological Strategies	Non-Pharmacological Strategies
Dyspnea & Anxiety related to Dyspnea	**Recommended treatment to relieve discomfort of breathlessness** If Resident is on opioids, give regular breakthrough doses to treat dyspnea If Resident is opiate naïve: **Morphine** 2.5 mg po q4h and 2.5 mg po q1h prn ***Morphine*** *1 mg subcut q4h and 1 mg subcut q30min prn* **OR** **HYDROmorphone** 0.5 mg po q4h and 0.5 mg po q1h prn **HYDROmorphone** 0.25 mg subcut q4h and 0.25 mg subcut q30min prn ***See Appendix 4 for information about medication availability via Ontario Drug Benefit (ODB) or Limited Use (LU) Code**	• Open window • Fan blowing air • Quiet calm atmosphere • Consider oxygen therapy at low flow rate if Resident is hypoxic • **COPD Considerations:** Ensure bronchodilators and other concomitant therapies are maximized for effectiveness. Opioids are safe and effective so long as initiated with low doses and less frequently • **Heart Failure (HF) Considerations:** Optimize HF treatments, including diuretics. Exclude reversible causes such as airway infection, pericardial or pleural effusions **Note:** • subcut dose = ½ the oral dose • if using multiple subcut injections, consider the use of a subcut port. Please follow organizational policies • HYDROmorphone is equivalent to a 5:1 ratio with Morphine • At end of life, morphine is a safe and effective consideration for the management of dyspnea
End Stage Delirium/ Restlessness	**Identify the goal of treatment** • Mild: **Haloperidol** 0.5 to 1 mg po/subcut q1h prn plus or minus (±) 0.5 to 1 mg po/subcut daily or bid • Mild: **Methotrimeprazine** 2.5 to 5 mg po/subcut q1h prn ± 2.5 to 5 mg po/subcut daily or bid • Moderate: **Haloperidol** 2 mg po/subcut q1h prn ± 1 to 2 mg po/subcut bid to tid • Moderate: **Methotrimeprazine** 5 to 12.5 mg po/subcut q1h prn ± 5 to 12.5 mg po/subcut bid to q8h • Severe: **MIDazolam** 1 to 5 mg subcut q30min prn if sedation is the primary goal and/or other treatments have failed	**Identify possible cause:** Rectal impaction, urinary retention, increase in pain, medications (opioids, corticosteroids), metabolic derangements (diabetes, hypercalcemia), and dehydration, hypoxia and brain metastases **Treat the cause with consideration of goals of care** • Explain to the family that the symptoms are caused by the illness and are not within the Resident's control and will fluctuate. • Encourage family members to provide gentle, repeated reassurance and avoid arguing with the Resident • Provide a quiet calm environment

Symptom	Pharmacological Strategies	Non-Pharmacological Strategies
Nausea	**Haloperidol** 0.5 to 1.0 mg subcut q4h prn	• Complete thorough assessment aimed at identifying the cause of the nausea and vomiting • Consider environmental modification to reduce strong smells and use air fresheners if tolerated • Maintain good oral hygiene, especially after episodes of vomiting
Pain	**<u>If Resident is taking an opioid</u> consider increasing dose by 25% for pain crisis** **GFR = 30-40: consider starting q6h** <u>If Resident is opioid naïve:</u> **Morphine** 2.5 mg po q4h and 2.5 mg po q1h prn ***Morphine** 1 mg subcut q4h and 1 mg subcut q 30 min prn* **<u>OR</u>** **HYDROmorphone** 0.5 mg po q4h and 0.5 mg po q30min prn **HYDROmorphone** 0.25 mg subcut q4h and 0.25 mg subcut q30min prn **Dexamethasone** 4 mg subcut daily may be added to manage escalating pain as a short-term therapy.	• Complete a thorough pain assessment and calculate total amount of analgesics used in past 24 hours to facilitate orders • Watch for nausea & vomiting, constipation, sedation, confusion, hallucinations, myoclonus • **FentaNYL** patches should not be started at end of life. If already in use, do not increase patch, use subcut opiate for breakthrough pain • **It is best practice to use ONE opioid** **Note:** • subcut dose = ½ the oral dose • Ongoing monitoring for constipation is essential. Consider the use of stimulant and/or osmotic laxatives if using opioids
Seizures	**For seizure lasting more than 2 minutes or reoccurring seizures:** **MIDazolam 5 mg subcut stat** and repeat every 10 minutes to a total of 3 times if seizure persists	• During a seizure clear the area of hard or sharp objects to prevent injury • Maintain airway • Review goals of care, if appropriate consider transfer to hospital if ineffective • When seizure is over, position Resident in a stable side position (recovery position) until he/she is alert • Keep calming environment for Resident and family • Contact physician/ nurse practitioner for additional orders as needed • Long half-life in elderly causing prolonged sedation (days)
Terminal secretions	**Scopolamine** 0.4 mg subcut q4h prn May cause: dry mouth, sedation / drowsiness or agitation in Residents who are still conscious.	• Normalize the sound. Use the opportunity to educate families on the physiology of terminal secretions and how the medication works to prevent additional secretion production. • If not responsive in 2-3 doses, will likely not respond • Repositioning to lateral recumbent with head slightly raised • Periodic mouth care should be done for comfort. • In rare situations suctioning may be of use although not routinely recommended

APPENDIX 2

General Indicators of Decline [5]

Are there general indicators of decline and increasing needs?

- Advancing disease - unstable, deteriorating complex symptom burden
- Decreasing response to treatments, decreasing reversibility
- Choice of no further disease modifying treatment
- General physical decline
- Declining functional performance status (e.g. Palliative Performance Scale (PPS))
- Co-morbidity is regarded as the biggest predictive indicator of mortality and morbidity
- Weight loss: >10% in past six months
- Repeated unplanned/crisis emergency department visits or hospital admissions
- Sentinel event, e.g. serious fall, bereavement, retirement on medical grounds
- Serum albumin <25 g/L

APPENDIX 3

Nursing staff responsibilities when caring for Residents in the last days of life include:

- Recognising when a Resident is approaching end of life and organising care plans, including end of life medications to address potential suffering.
- Initiating appropriate non-pharmacological strategies to manage symptoms.
- If suspecting urinary retention: assess for anxiety, delirium, confusion and distress. Insert Foley catheter prn.
- Keeping Resident and family informed of changes in the Resident's condition as well as changes in treatment plans.
- Requesting that the physician or nurse practitioner pre-emptively prescribe and chart medication orders to manage common end of life symptoms.
- Monitoring swallow, and if it deteriorates, requesting oral medication orders be reassessed for using an alternative route or ceased if no longer required.
- Regular reassessment of symptoms and the efficacy of all interventions.
- Monitoring for medication side effects.
- Organising physician/nurse practitioner review if symptoms are not well managed or if medication is not tolerated.
- Contacting the physician, nurse practitioner or local specialist palliative care service for further advice if symptoms are not responding to treatment.

APPENDIX 4

Medications Availability via ODB or LU Code: [6] found within the WW EOL Medication Order Set for LTC

- Morphine 10 mg/mL - LU Code 481
- HYDROmorphone (Dilaudid) 2 mg/mL
- Haloperidol (Haldol) 5 mg/mL
- Methotrimeprazine (Nozinan) 25 mg/mL
- MIDazolam (Versed) 5 mg/mL - LU Code 495
- Scopolamine (Hyoscine Hydrobromide) 0.4 mg/mL - LU Code 481

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