Guidance for care of patients in the last days of life

REVIEW and RECOGNISE

Deterioration in the patient's condition suggests the patient is likely to die in hours or days

1. Consider and treat appropriately reversible causes e.g. opioid toxicity, renal failure, infection, hypercalcaemia.
2. Is specialist opinion needed from a consultant with experience in patient's conditions?
3. Is there an Advance Care Plan or an Advance Decision to Refuse Treatment (ADRT)?*
4. Are preferred places of care and death known?

SENIOR DOCTOR/GP/MULTIDISCIPLINARY TEAM ASSESSMENT MINIMUM EVERY 3 DAYS

COMMUNICATE

COMMUNICATION

When the doctor or nurse has identified that a patient is dying or is likely to die, they must discuss and agree an individual plan of care with the patient (if they have the capacity and wish to be involved in decisions) and/or the family or carers.

Not all patients wish to discuss they are dying. In this situation it may be appropriate to have a discussion that their condition is likely to be irreversible.
Some patients may wish their families to be involved in these discussions. It is good practice to involve families in discussions and document any concerns raised and your response to these.

Ensure the names of the senior doctor and nurse responsible for the patient's care are made known to the patient, family and carers.

DOCUMENT

DOCUMENTATION
The doctor or nurse must ensure that the individual plan of care and all conversations are clearly documented in the patient's clinical records.
DNACPR decisions need communicating and documenting.

RE-EVALUATE

Patient's condition improved and is no longer likely to die - request medical review

Explore the patient's and the relatives' understanding and wishes for treatment and care

Consider:
- Escalation/ contingency plans
- Define ceilings of treatment
- Timescale for review

DOCUMENT REVIEW

Patient is imminently dying and no reversible cause identified or patient opts for comfort care

Continue individual plan of care

Contact local palliative care service or OneCall service for advice or support if needed

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Outcome: To facilitate dying with dignity, comfort for patient and provide carers with support

Communicate and document

COMMUNICATE AND DOCUMENT

- Explain to patient and relatives that death is thought likely to be soon. (Use Independent Mental Capacity Advocate- IMCA *- when a patient lacks capacity and has no relatives or carers).
- Support them and ensure they are aware of the seriousness of the condition; that death is thought likely to be imminent and the focus of care is now on comfort primarily.
- Ensure the names of the senior doctor and nurse responsible for the patient's care are made known to the patient, family and carers.
- Document significant conversations in the notes, including DNACPR status, Advance Decision to Refuse Treatment (ADRT) and ceilings of treatment.
- Ensure contact numbers for key family members are recorded
- Discuss and document the patient's preferences and wishes, including Preferred Place of Care (PPC) and Preferred Place of Death (PPD)
- Give family/carers written information about the clinical changes that occur at the end of life

Review

REVIEW INTERVENTIONS AND MEDICATIONS – focus on comfort and support

- Consider interventions based on a balance of benefits and burdens including prescription of fluids
- Communicate decisions with patient (where possible) and family/carers
- Rationalise all medications

Care

MAINTAIN EXCELLENT CARE

- Ensure an individual plan of care is agreed between patient, healthcare professionals and family/carers
- Ensure dignity and compassion in all care
- Encourage and support oral food/hydration as patient is able. Provide regular mouth care
- Monitor bladder and bowel function, and take appropriate action
- Skin care and turning for comfort as appropriate

Symptoms

ASSESS SYMPTOMS – physical, psychological, social

- Prescribe medications for anticipated symptoms e.g. pain, nausea, agitation, respiratory secretions
- Administer medications via subcutaneous syringe pump if no longer tolerating oral medication or medically indicated
- Consider non-pharmacological interventions, eg complementary therapies

Family

IDENTIFY SUPPORT NEEDS OF FAMILY/CARERS

- Offer emotional support and access to supportive services if required
- Ensure contact numbers updated for key family members
- Explain facilities available
- Consider environment and privacy and when they would like to be contacted

Spirituality

IDENTIFY SPIRITUAL NEEDS

- Assess spiritual/religious beliefs and needs of patient and carers
- Document specific actions needed
- Consider referral to chaplain or own spiritual leader as required

After care

CARE AFTER DEATH

- Give emotional support
- Follow local procedures for verification and certification of death
- Offer family bereavement booklet
- Inform GP and other involved clinicians

Suggested starting doses for as required subcutaneous medication

NB these doses are appropriate starting doses for opioid naïve patients – for patients already taking regular opioids please contact the palliative care teams for advice.

If a patient has required multiple doses a syringe driver should be considered. Please contact palliative care team for advice.

For pain/breathlessness:
Morphine 2.5-5mg 2-4 hourly prn
Diamorphine 2.5-5mg 2-4 hourly prn

For agitation/anxiety:
Midazolam 2.5-5mg 2 hourly prn

For respiratory secretions:
Buscopan (hyoscine butylbromide) 10-20mg 6 hourly prn

For nausea/vomiting:
Haloperidol 500 micrograms -1.5mg prn 12-24 hourly
Cyclizine 50mg 8hourly
Levomepromazine 6.25mg 8 hourly prn

Drugs in bold are preferred medications

Contact Echo on 01903 254789 who will sign post accordingly

***For further details please see your website for links.**