LAST DAYS OF LIFE

INTRODUCTION

- This is a core skill for all clinicians
- High quality care in the last days of life is essential to ensure a peaceful and dignified death
- Involves complex decision making and can be emotionally challenging

RECOGNITION OF DYING

- Based on clinical assessment
- Consider potentially reversible conditions which can mimic dying
  - e.g. renal failure, infection and hypercalcaemia
- If patient clearly in the dying phase, treatment of specific medical problems may not provide benefit to the patient
- In cases of uncertainty or disagreement, a second opinion may be helpful

Responsibility for decision making

- Unless urgent and unavoidable, decision that patient is dying and any changes in treatment plan should be made in-hours by the responsible consultant

Communication

- Involve patients and their family in decisions about their care as far as possible
- Be open and honest
  - explain that patient is in the last days of life
  - acknowledge uncertainty about exact prognosis
  - explain any changes to the plan of care
  - allow patient and their family opportunity to ask questions
- Can be challenging as patients often fatigued, confused or with a reduced level of consciousness

REVIEWING THE PLAN OF CARE

Treatment escalation and limitation plan

- Assess whether current treatments and interventions provide a benefit to patient
  - e.g. making them more comfortable
- Decide which interventions would be helpful or not in the future
- If a resuscitation decision has not been made, address it now
  - the cessation of cardiac and respiratory function is part of the natural dying process
  - resuscitation cannot reverse this
- Document these decisions on the ReSPECT form and in the UHNM last days of life care bundle

Does patient have specialist palliative care needs?

- Refer to the palliative care team if:
  - pain or other symptoms, particularly if patient has required >2 doses of any PRN medication in last 24 hr
  - psychological distress
  - complex social or family concerns
  - assessment for a hospice bed

- difficult decision making

Nutrition and hydration

- Give all patients regular mouth care and support to take food and fluids when able
- Decide with each patient whether to continue/commence clinically assisted nutrition or hydration

Medications

- Prescribe SC anticipatory medications to treat common symptoms without delay
- If patient experiences symptoms or takes regular medications for symptom control (e.g. strong opioids), they may require continuous SC infusion of medication. See **Continuous subcutaneous infusions (CSCI) in palliative care** guideline

Anticipatory prescribing

- Prescribe the following for all patients
  - midazolam 2.5–5 mg SC hourly PRN for agitation or dyspnoea
  - haloperidol 1.5–2.5 mg SC 4-hrly PRN for nausea and vomiting (maximum 5 mg/24 hr)
  - hyoscine butylbromide 20 mg SC 4-hrly PRN for respiratory secretions (maximum 120 mg/24 hr)
  - morphine sulphate 2.5–5 mg SC hourly PRN for pain or dyspnoea

Circumstances when prescribing may differ

- If patient has renal impairment (i.e. eGFR <50ml/min/1.73m^2), hepatic impairment or is taking regular strong opioid, dose or type of opioid medication may need adjustment
- If patient has severe renal impairment (i.e. eGFR <20ml/min/1.73m^2, on peritoneal or haemodialysis) adjust medications and doses as follows:
  - midazolam 1.25–2.5 mg SC hourly PRN for agitation or dyspnoea
  - haloperidol 0.5–1.5 mg SC 4-hrly PRN for nausea and vomiting (maximum 5 mg/24 hr)
  - hyoscine butylbromide 20 mg SC 4-hrly PRN for respiratory secretions (maximum 120 mg/24 hr)
  - oxycodone 1.25–2.5 mg SC hourly PRN for pain or dyspnoea

DOCUMENTATION

- Document clearly decisions, plan of care and discussions with patient or family
- Use local documentation
- Use the purple bow scheme