Guidance- Caring for the Dying Patient

Updated Sept 2018

NHS Northern England Clinical Networks

This guidance is based on the Leadership Alliance for the Care of Dying People: Priorities for Care:

Recognising dying

1. The senior responsible clinician must make an assessment that the patient is dying.

Communication and Involve

2. Make a plan, in consultation with the patient if possible, and involving their relative/carer if appropriate:
    a. Identify any relevant decisions made in advance (e.g. ADRT, DNACPR etc.)
    b. Decide about any relevant monitoring/ investigations/ interventions.
    c. Assess symptoms and agree options for symptom control
    d. Explore the patient and relative/carer's understanding and concerns about the situation
    e. Identify the patient's current wishes, beliefs, values and spiritual needs.
    f. Discuss and agree with the patient and their relative(s)/carer(s) the options regarding hydration and feeding. Patients should be offered food and drink if they can swallow.

Support, Plan and Do

3. Confirm and document the assessment, plan of care and the conversations that have taken place on **the regional Caring for the Dying Patient document.**
4. Ensure that any medication or equipment that may be required has been prescribed, is available and has been discussed with the patient and their relative/carer.
5. Medication must be prescribed subcutaneously on an 'as required' basis for symptoms that commonly occur at end of life (pain, agitation, respiratory secretions, nausea/ vomiting and breathlessness).
6. Patients requiring regular medication should have a syringe driver prescribed with the lowest doses needed to manage their symptoms. The purpose of the syringe driver and medication should be fully explained, as well as any common side-effects eg. drowsiness.

This plan should be recorded on the initial Medical and Nursing assessment on the regional Caring for the Dying Patient document as well as any additional care plans. Ensure anticipatory medications are prescribed and available.

Out of hours services should be informed of a patient who is dying in the community.

Team responsibilities:

Senior responsible clinician

1. All dying patients must have an identified senior responsible clinician who will make key decisions. This is the patient's named GP or Consultant, and can be delegated out of hours.
2. Clinical teams should be constantly reviewing deteriorating patients and planning ahead, reviewing escalation decisions and anticipating end of life situations.
3. The recognition that the patient is dying should be made by the senior clinician in consultation with the patient/ family and clinical team. Out of hours in hospital, a Registrar or Consultant should be responsible for making the decision that someone is dying, if this situation has not been anticipated. In the community, the on-call GP will make the decision.
4. The senior responsible clinician should make key decisions, unless it is an emergency. They should regularly review whether the patient is still expected to die.

Regular re-assessment of patients

5. Patients need to be re- assessed regularly to have their treatment and care needs re-evaluated and addressed. There needs to be regular communication with patients and their families.

Hospital:

- At least daily medical assessment (***using medical reassessment sheet***)
- At least 4 hourly nursing assessment (***using the daily ongoing assessment and nursing care sheet***)
- Regular assessment by the senior responsible clinician (***using medical reassessment sheet***)

Community/ community hospitals:

- At least three times daily nursing assessment (***using the daily ongoing assessment and nursing care sheet***)
- Regular assessment by a doctor (***using medical reassessment sheet***)
- Regular assessment by the senior responsible clinician (***using medical reassessment sheet***.

Daily Patient Assessment Checklist

Assessment:
-Patient/ relative/ carer concerns
-Events, changes in problems/ symptoms
-Hydration, nutrition, continence, cognitive status
-Examination: mouth, skin, presence or absence of pain/ distress/ upper resp. secretions/ breathlessness/ nausea/ vomiting

Check:
-**Has there been a significant deterioration <u>or improvement</u> in the patient's condition?**
-Drug chart for PRN use of any medications
-Are necessary PRN medications prescribed and those medications which the patient cannot take discontinued?
-Do the nursing staff have any concerns?
-Has spiritual care been considered?
-Needs of carers including after death

Management:
-Does the current management plan need to change?
-Do any drug doses or routes require adjustment?

Discharge/Setting:
-Is the patient in their preferred place of care?

Escalation:
-Do you need to discuss this patient with a more senior colleague?

Speak to:
-What does this patient/ carer want to know about what is happening?
-Do they have any questions or concerns?
-Have you handed over any key information to other team members

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Palliative care contact details:

Community palliative care teams
Contact Details:

Hospital palliative care teams
Contact Details:

Hospice
Contact Details:

Out of hours palliative care advice:
Contact Details:

SYMPTOM CONTROL IN DYING PATIENTS

Refer to NORTHERN ENGLAND CLINICAL NETWORK PALLIATIVE AND END OF LIFE CARE GUIDELINES 2016

ANTICIPATORY PRESCRIBING–"as required" subcutaneous injections

SYMPTOM	Drug	Dose	Frequency/ Total Dose
Pain	**Morphine**	2.5-5mg	1 hrly
	NB. Dose/ drug adjusted for patients currently taking opioids or with renal impairment, morphine intolerance- see full guidelines		
Nausea & Vomiting	**Haloperidol** (chemical cause: drug, renal impairment, metabolic, infection)	1.5mg	Max 5mg/ 24hrs
	Cyclizine (other causes)	50 mg	Max 150mg/ 24hrs
Agitation / restlessness	**Midazolam**	2.5-5 mg	1 hrly
	Haloperidol (delirium)	1.5 mg	1 hrly, max 5mg/ 24hrs
Respiratory secretions	**Hyoscine Hydrobromide OR Hyoscine Butylbromide**	400microg 20mg	1 hrly, max 2400microg/24hours 1 hrly, max 120mg/24hours
Dyspnoea	**Morphine** or **Midazolam**	See above	

***PLEASE SEEK PALLIATIVE CARE TEAM ADVICE IF SYMPTOMS NOT SETTLING AND MAXIMUM RECOMMENDED DOSES REACHED.**
PATIENTS MAY REQUIRE HIGHER DOSES OR MORE FREQUENT INJECTIONS*

24 HR SYRINGE DRIVER PRESCRIBING- full individualised assessment required

Use if persistent symptoms, on regular oral symptom medication or requiring > 2 as required injections

-Nausea and vomiting: Switch route of current drug or **Cyclizine** 150mg/ 24hrs or Haloperidol 3mg/ 24hrs

-Respiratory secretions: **Hyoscine Hydrobromide** 1.2mg/ 24hrs, increase to 2.4mg if needed **OR** **Hyoscine Butylbromide** 60mg/24hrs, increase to 120mg if needed

-Pain: ***Morphine**
-if on regular oral morphine, convert to syringe driver (divide 24hr oral dose by 2)
-if on other opioid, see guidelines for conversion
-if renal impairment, see guidelines for advice
-starting dose 10mg/ 24hrs if not previously on opiate (reduce if appropriate)

-Agitation/ restlessness: ***Midazolam** 10mg/ 24hrs or Haloperidol 3mg/ 24hrs

*Dose in syringe driver may need to increase if ongoing symptoms requiring ≥2 PRN doses in 24hours. Dose should be increased either by 30-50%, or by adding in total amount of as required injections, depending on clinical assessment.