END-OF-LIFE CARE

PALLIATIVE CARE PROJECT ECHO, SEPTEMBER 2022

"How people die remains in the memories of those who live on"
- Dame Cicely Saunders

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Discussion points

1. Recognising dying
   – transition to terminal care

2. Caring for dying patients
   – care plan
   – symptom control

3. Supporting patients and families
   – communication
   – bereavement support

4. Dealing with your own emotions

Palliative Care Principles remain important throughout a terminal illness and at the time of death

Holistic Palliative Care

- Patient & family centered care
- Focus on quality of life
- Appropriate goals of care
- Holistic multidisciplinary care
- Seamless transition between care settings

Transition to end-of-life care
[when death is imminent – days or hours]

1. Recognize the patient is dying
2. Review current management
    - focus on appropriateness for dying person
3. Review symptom control
4. Psychological and spiritual needs
5. Family & carer needs
    - information & support
    - care of the body after death
    - care of family after death

Diagnosing Dying

“Dead dad” by Ron Mueck

1. Liverpool EoLC “gateway criteria”:

1. Multidisciplinary team agree patient has hours or days to live
2. NFR order discussed & documented
   - “allow natural dying”
3. Decreased function: >2 of
   - ✓ bed-bound
   - ✓ semi-comatose
   - ✓ can no longer take tablets
   - ✓ can only take sips of fluids

2. Physical & functional changes in last hours to days:

- reduced activity / communication / oral intake / urine output
- irregular (Cheyne-Stokes) breathing
- skin changes: coolness, pallor, cyanosis

Review Plan of Management

- Ensure patient and family are aware of dying
  - discuss plan of care
  - ensure ARP discussed & recorded
  - contact information
- Discontinue inappropriate interventions
  - eg. blood tests, antibiotics, IVT….
- Assess current medications:
  - stop non-essential meds
  - if needed convert oral drugs to SC
  - write PRN & regular SC meds for symptom control

Pro-active collaborative care plan

- Meet with patient, carer & family, and the staff who will be supporting them
  - assign roles, discuss frequency of visits, exchange numbers
  - leave orders eg to permit catheter or enema
  - good if everyone is on the same page
  - reassuring to everyone

- GPs: Do you need to discuss with a palliative care physician?

- Plan ahead re medications or equipment
  - review and medication titration: who? how often?
  - sourcing medications:
    - parenteral meds not always easily available
    - enough to cover weekends and public holidays

Reduce suffering

Nikki Syringe Driver

- Reduce interventions
  - investigations
  - nursing cares: observations, turns, washes
  - external noise & activity, visits
- Give appropriate medications
  - appropriate doses
  - via appropriate route, eg SC
  - regular & rescue (‘PRN’) approach
  - frequent review and titration

Symptom control

- Many people die without any symptoms or distress at all, *but*
- Dying is an *inherently changeable* process, so it's good to plan ahead (pro-active approach to care)
- *Regardless of the patient's illness*, the most common EOL symptoms are:
  - Pain
  - Nausea
  - Dyspnoea
  - Restlessness
  - Delirium
  - Excess secretions

Pain

- **Management depends on *prior needs*, *current status*, & *availability of medications & equipment.***
- **Not everyone needs a SD: alternatives? PRN +/- regular bolus SC meds**
- **Remember not all distress is pain: (i) exclude full bladder etc; (ii) agitation = > use sedation**

Opioid naïve?

morphine 5 mg oral or 2.5 mg SC Q 4 hrs PRN

>3 doses in 24/24?
- consider CSCI 10-20 mg/24 hr
- useful for mixing other EOL meds

Contraindications to morphine:

- morphine allergy - rare
- ESRF
  - alternatives: fentanyl, hydromorphone, oxycodone.
  - if actively dying ie very short prognosis and you only have morphine, use that
  - hydromorphone very potent: take care

On opioids?

- if cannot swallow consider continuing regular analgesia with 24/24 CSCI
- morphine, fentanyl, oxycodone, methadone and hydromorphone can all be used SC
- if increased pain, increase from usual opioid dose
- you don’t have to remove an analgesic patch, just supplement with the SD
- opioid SC dose = 1/3 oral equivalent
- breakthrough dose = 1/6 –1/10 of 24/24 hr dose

Nausea & vomiting

Drugs: CONSIDER THE CAUSE	Comments
Metoclopramide 10mg SC TDS; 30mg/24 hours via CSCI	Avoid in bowel obstruction, Parkinson's Disease, dystonias or akathisia...
Haloperidol 0.5-1.5 mg SC BD; 1-3 mg/24 hrs via CSCI	Can be useful if delirium present Avoid if Parkinson's Disease Antipsychotic
Cyclizine 25-50 mg SC Q 6-8 hrs; 50-100 mg/24 hrs CSCI	Useful alternative if pt has bowel obstruction, Parkinson's Disease or as 3rd line Sedating
Levomepromazine 6.25-12.5 mg SC QID; 25 mg/24 hours via CSCI	Useful in patients with nausea + agitated delirium Antipsychotic Available through SAS scheme

Dyspnoea

- midazolam 1-2.5 mg SC Q 2 hrs PRN

  and/or

- morphine 2.5 – 5 mg SC Q 4 hrs PRN

- either/both can be added to a syringe driver over 24 hrs via CSCI
- family support, nursing cares, positioning, fan, window open
- (oxygen)
- assisted ventilation / ceasing assisted ventilation at EOL

Agitation & Restlessness

- **Exclude pain, full bladder, full bowel**
- **Sedation with benzodiazepines won't be effective if the patient also has a delerium**

Sedation for agitation: midazolam 2.5–5mg SC Q 2/24 PRN ○ if >3 doses needed in 24 hrs: = > CSCI 10-20 mg/24 hrs *or* ○ add bolus clonazepam 0.5-1 mg SC BD	• Bolus midazolam is very short acting, clonazepam longer-acting • Don't put clonazepam in a SD
Delerium: haloperidol 0.5–1.5 mg SC BD-TDS ○ if >3 doses needed in 24 hours: = > CSCI 1-5 mg/24 hrs	• Haloperidol (and other antipsychotics) are also helpful for treating nausea. • Alternatives if ineffective: Levomepromazine, olanzepine, phenobarbitone

Respiratory tract secretions

Drug choice: - they all work well!	Comments: give early to prevent secretions
atropine 0.6 mg SC Q 4 hrs PRN; CSCI 2.4 mg/24hrs	Widely available Dry mouth Potential cardiac effects
hyoscine hydrobromide O.4 mg SC Q 4 hrs PRN; If >2 doses in 24 hrs => CSCI 1.6 mg/24hrs	Can cause confusion, sedation, dry mouth People get their “hyoscine’s” mixed up!
hyoscine butylbromide 20mg SC Q 6 hrs PRN; CSCI 40-80 mg/24hrs	Doesn’t cross blood-brain barrier Longer action > good in community setting
glycopyrrolate 0.2-0.4 mg Q 6 hrs PRN; CSCI 0.6-1.2 mg/24 hours	Doesn’t cross blood-brain barrier

Supporting patients and families

- Good communication:
  - ‘right family, right story, right timing’
  - listening, time, trust
  - use *plain English*
  - interpreting, liaison, advocacy

- Assess needs for social, cultural, religious or spiritual support
  - respect patients & families; their choices, customs, & beliefs
  - refer as appropriate
  - ask if you don’t know

These Chinese characters make up the verb
‘to listen’
Ear
You
Eyes
Undivided
Attention
Heart
聽

Self care: “Emotional work”

- Confronting death:

  - what do the ideas of death, aloneness, meaninglessness, personal freedom, mean to you?

- Dealing with the emotions of others
  - grief, anger, love
  - supporting others: patients, families, staff

- Dealing with our own feelings
  - sadness, fallibility, powerlessness
  - maintaining boundaries

- What helps you manage?

Summary: end-of-life care

- Recognise dying
- Review management
- Control symptoms
  - anticipatory prescribing
  - regular & prn medications
  - regular review
- Communicate well with patients, family and staff
- Attend to psychological, spiritual & cultural needs
- Look after and support yourselves