END-OF-LIFE CARE

PALLIATIVE CARE PROJECT ECHO, SEPTEMBER 2023

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"How people die remains in the memories of those who live on"

- Dame Cicely Saunders

Principles

- Palliative Care Principles are important throughout a terminal illness including at the time of death:
  - Patient & family centred care
  - Focus on quality of life
  - Appropriate goals of care
  - Holistic multidisciplinary care
  - Seamless transition between care settings

Holistic Palliative Care

- Regardless of the illness, a similar approach to patient care helps:
  - Recognising dying -> transition to end-of-life care
  - Caring for dying patients
  - Supporting patients and families
  - Dealing with your own emotions

Diagnosing Dying

"Dead dad" by Ron Mueck

1. **Physical & functional changes in last hours to days:**

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

2. **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

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

1. Information and awareness: are patient and family aware?
   - discuss plan of care with staff and family
   - ensure ARP discussed & recorded
   - contact information

2. Review current management: is it appropriate for a dying person?
   - stop non-essential meds
   - discontinue inappropriate interventions eg tests, antibiotics, IVT, nursing observations…

3. Review symptom control: are they comfortable?
   - if needed convert oral (symptom control) drugs to SC
   - write PRN & regular SC meds for symptom control - PLAN AHEAD

4. Psychological and spiritual needs
   - for patient and family
   - privacy

Symptom control

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

Pain

- *Not all distress is pain*: consider full bladder or bowel, agitation, emotions
- *Not everyone needs a SD*: alternatives? PRN +/- regular bolus SC meds

- Management depends on prior medications, current status, & availability of medications & equipment. If patient cannot swallow:

a) if opioid naïve:
   - start with morphine 2.5-5mg SC Q 3-4 hrs, or 10-15mg /24 hrs CSCI
   - note morphine is contraindicated in ESRF: use fentanyl, hydromorphone, [oxycodone]

b) if on a previous opioid:
   - SC dose = 1/3 oral equivalent
   - continue prior regular opioid analgesia with 24/24 CSCI (if increased pain, increase dose)
   - breakthrough dose = 1/6 –1/10 of 24/24 hr dose

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

Nausea & vomiting

Drugs: CONSIDER THE CAUSE	Comments
Metoclopramide 10mg SC TDS; 30mg/24 hours via CSCI	Avoid if bowel obstruction, Parkinson's Disease, dystonia or akathisia...
Haloperidol 0.5-1.5 mg SC BD; 1-3 mg/24 hrs via CSCI	Avoid if Parkinson's Disease Antipsychotic: useful if delirium present
Cyclizine 25-50 mg SC Q 6-8 hrs; 50-100 mg/24 hrs CSCI	Useful if bowel obstruction or Parkinson's Disease Sedating
Levomepromazine 6.25-12.5 mg SC QID; 25 mg/24 hours via CSCI	Useful if nausea + agitated delirium Antipsychotic Sedating

Agitation

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

Agitation

- midazolam 2.5–5mg SC Q 2/24 PRN
- if >3 doses needed in 24 hrs:
- = > CSCI 10-20 mg/24 hrs

or

- bolus clonazepam 0.5-1 mg SC BD

❖ Midazolam is very short acting

❖ Don't put clonazepam in SD

Delirium

- haloperidol 0.5–1.5 mg SC BD-TDS PRN
- if >3 doses needed in 24 hours:
- = > CSCI 1-5 mg/24 hrs

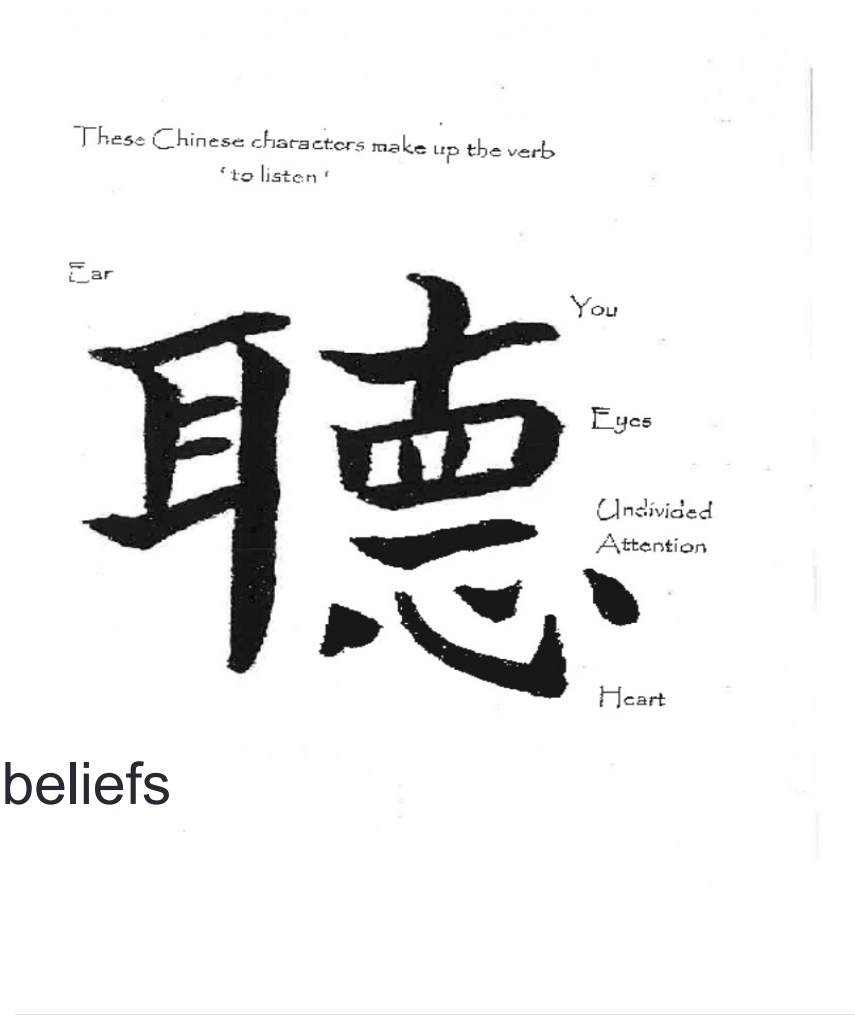
- haloperidol (& other antipsychotics) are also helpful for treating nausea.
- 2nd line: levomepromazine, olanzepine
- 3rd line: phenobarbitone

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 “hyoscines” mixed up!
hyoscine butylbromide 20mg SC Q 6 hrs PRN; CSCI 40-80-120 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 0.6-1.2-1.8 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



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

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?