CDHB End of Life Care Plan

Deterioration in patient's condition suggests the patient may be dying, e.g. increasingly weak, sleepy, uninterested in getting out of bed, decreased oral intake & less interested in surroundings

Multidisciplinary Team Assessment (MDT)
Is there a potentially reversible cause? e.g. hypercalcaemia, renal failure, infection, hypoactive delirium, drug toxicity. Could the patient be approaching the last days of their life? Is further support needed to assess & manage condition? Is a referral to the palliative care team required?

Patient is **NOT** diagnosed as dying

Review the current plan of care daily based on a thorough patient assessment

Resuscitation Status

This needs to be addressed & discussed with the patient / family as appropriate.

Ensure that a DNACPR form is completed.

Patient **IS** diagnosed as dying
Remember: End of life care is the responsibility of ALL staff

Patient (if appropriate) & family communication is focussed on recognising & understanding wishes, fears & concerns around dying, including preferred place of death

Explain current plan of care which is to focus on comfort. Clarify expectations, use of medications & other strategies.
Dignity & comfort are now the priority

Daily assessment & regular discussions with family

Comfort Cares

"At the end of life each story is different"

Physical Comfort

It is not necessary to do further observations, bloods, tests & investigations. Constantly assess comfort in a holistic manner.

Be alert for:

- Discomfort & pain (failure to address psychological distress & social / cultural issues is a common cause of unrelieved pain)
- Restlessness / agitation
- Respiratory distress
- Retained secretions
- Nausea / vomiting
- Confusion / hallucinations / delirium

Also check for:

- Pressure areas / skin integrity
- Faecal impaction / overflow. A PR may be necessary if suspected
- Urinary retention

Psychological & Spiritual Needs

- Encourage conversations with family / whanau in an open & honest manner to elicit any fears and concerns
- Avoid withholding difficult information
- Encourage a relaxing environment, e.g music at low volume & soft lighting
- Keep distracting noises like televisions & radios to a minimum
- Encourage loved ones to reminisce
- Respect the family's need for privacy
- Honour their wishes. Is there a current & valid Advance Care Plan? Have there been informal advance care planning discussions?
- Offer Chaplain and family / whanau support services

Resources available:

- "When Death is Near" http://healthinfo.org.nz/30259.htm
- "When someone dies in hospital" http://www.cdhb.health.nz/Patients-Visitors/Pages/When-someone-dies-in-hospital.aspx
  The pamphlet is also available from the Mortality Office ext: 81019

Medications

- Rationalise all current medications & stop those not required for comfort (including IV fluids)
- Consider route of administration – usually subcutaneous at this stage
- Chart anticipatory medications all subcutaneously (refer to the palliative care website)
  1. Opioid – pain, discomfort, shortness of breath
  2. Buscopan – secretions (death rattle)
  3. Haloperidol – nausea, confusion, agitation, delirium
  4. Midazolam – agitation, distress, anxiety, shortness of breath

Opioids: morphine is the gold standard (renal function dependent).

Physical Cares

- Regular mouth cares (to alleviate dry mouth and thirst)
- Bowel / urinary cares
- Skin cares
- Body positioned and covered appropriately for comfort (hot / cold)
- Surroundings safe and tidy
- Encourage family / whanau involvement, e.g. holding hands, washing, mouth cares, touch & gentle massage

"Dignity and privacy are commodities beyond value in the dying"

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Canterbury District Health Board
Te Poari Hauora ō Waitaha