GUIDELINES FOR GOOD CARE OF DYING PATIENTS

This guidance is to be used for patients thought to be dying within the next few days.

- Care should be taken to document all decisions and discussions carefully in the patient's notes.
- If advice is required at any stage, please contact a senior member of your team or the Palliative Care Team on ....
- Patients should be reviewed at least 4 hourly in hospital or daily in the community.

Recognise

Recognition that the patient is dying

Please consider possible reversible causes for the patient's deterioration.

The decision that a patient is approaching end of life should be made by a named senior clinician and, ideally, someone who has been caring for the patient. The decision should be made in consultation with the wider clinical team and documented in the notes.

Inform patient's GP (or wider health care team) of expected deterioration.

Communicate

Communication with the patient and family

Patients and carers should be made aware of their named consultant/responsible clinician.

Clinicians should communicate with the patient (where possible and appropriate) and families regarding:

(a) The patient's prognosis (be aware that not all patients wish to discuss this).
(b) The goals of treatment/care.
(c) Their preferred place of care.

Document these decision processes and discussions in the patient's notes.

Involve

Meeting patients' wishes

Consider whether the patient has:

(a) An Advance Decision to Refuse Treatment (Living Will).
(b) An Advance Care Plan.
(c) An expressed wish for organ/tissue donation.
(d) A Lasting Power of Attorney for health and welfare.

Record these in the patient's notes.

Complete EPACCS register for patients in the community.

Record the psychological and spiritual needs of the patient

Resuscitation Discussion and Treatment Escalation Plan

Decide levels of appropriate intervention and discuss sensitively with the patient (if appropriate and possible) and family.

Support

Meeting psychological and spiritual needs

Assess family and those who are important to the patient for their psychological and spiritual needs.

Plan and Do

Review investigations, interventions and treatments

Continue with measures aimed at optimising the patient's symptom control and comfort.

Stop unnecessary interventions, eg blood tests, IV fluids, IV antibiotics.

Stop unnecessary observations, eg blood pressure, pulse, oxygen saturations. Note it may be important to continue to monitor CBGs in an insulin dependent diabetic (see local guidance).

If the patient has an implantable cardiac defibrillator (ICD), seek advice from Cardiology.

Document these decision processes and discussions in the patient's notes and discuss with the family.

Control of symptoms

All patients should be medically reviewed regularly to ensure they are comfortable and not distressed.

Stop non-essential medications.

Assess patient for symptoms including pain, agitation, breathlessness, nausea and vomiting, respiratory secretions, urinary problems and dry mouth.

Consider converting appropriate medications to a syringe pump. If a syringe pump is commenced, it is essential that the reasons for this are discussed with the patient (where possible) and family members, and these discussions documented.

Write up prn medications for pain, nausea and vomiting, agitation, breathlessness and respiratory secretions (please see prescribing guidance).

All medications used, including sedative medication, must be targeted at specific symptoms, used in the smallest doses that work for the shortest time necessary and their use regularly reviewed and adjusted.

Feeding and fluids

All patients who are able to take sips of fluid should be offered drinks regularly. If a patient's swallowing is impaired, they may still choose to take sips and this should be assessed on an individual basis to maximise overall comfort.

Consider the possible benefits and burdens of artificial hydration and nutrition.

Document discussions with patient and family regarding food and fluids carefully.