Guidance At End of Life (GAEL) for Health Care Professionals

For use when:

- There is irreversible deterioration
- Ceilings of treatment/interventions have been reached
- Investigations either no longer appropriate or desired by the patient
- Clinical judgement of multi-disciplinary team (MDT) is that the patient is dying and the Senior Clinician agrees with this.

Contact your local palliative care team for advice – Community Teams, Hospital Teams

Significant decisions about a patient’s care including diagnosing dying, are made on the basis of multi-disciplinary discussion

- Regular discussion, review and consideration should be given to decision making and management/treatment plans based on assessment of the needs of the patient/relative/carer/friend.
  - Medical interventions/Nursing interventions including the use of the assessment tools – consider discontinuing those that are no longer beneficial to the patient
  - Do Not Attempt Cardio Pulmonary Resuscitation (guidance overleaf)
  - Regular review of nutrition and hydration needs. Discuss with the patient/relative/carer/friend the benefits or burdens of artificial hydration/nutrition (GMC Good Practice Guidelines / NICE Guideline: Care of Dying Adults in Last Days of Life)

- Medication
  - Assess individualised needs of the patient
  - Rationalise non essential medications and consider individualised anticipatory prescribing. See guidance overleaf
  - Use of continuous subcutaneous infusion if patient is struggling to swallow, or has uncontrolled symptoms not helped by oral or subcutaneous (SC) breakthrough doses
  - "Just in case" boxes should be available to patients in the community setting
  - Preparing the patient (if appropriate) relative/carer/friend if there is an identified risk of a significant event e.g. catastrophic bleed

Informative, timely and sensitive communication is an essential component of each individual patient’s care

- Regular communication and review of care with the patient/relative/carer/friend and the multi disciplinary team is essential. Ensure any potential communication barriers are identified and addressed e.g. use of interpreters.
- Clearly document any significant conversations (where available use SBAR)

Advance/Anticipatory Care Planning

- Identify what is now important to the patient/relative/carer/friend? Does the patient have My Thinking Ahead and Making Plans tool or a Key information Summary (eKIS)
- Does the patient have –
  - An Anticipatory Care Plan?
  - An Advanced Directive/Living Will?
- Has the patient’s capacity been assessed? If the patient does not have capacity, Section 47 AWI certificate and treatment plan should be completed.
- Does the patient have Welfare Power of Attorney/Guardianship in place? Has the Guardian/Attorney been identified and included in discussions? Do we have a copy?
- Discuss preferred place of death. To facilitate transfer see the Rapid Discharge Guidance for Patients who are in the Last Days of Life.
- Preparing the patient/relative/carer/friend that they are dying - what can happen (‘What Can Happen When Someone is Dying’)

Each individual patient’s physical, psychological, social and spiritual needs are addressed as far as is possible

- Ask questions, listen and respond to worries and fears
- Regular assessment of the patient’s physical symptoms, including bowel and bladder function, as these are treatable causes of distress at end of life
- Continuous review of nutrition and hydration plan. Regular mouth care and oral fluids as able.
- Where possible identify spiritual, religious and cultural needs both before and after death
- Offer to contact Chaplaincy service or their preferred faith/community leader.

Consideration is given to the well-being of relatives or carers attending the patient

- Keep relative/carer/friend updated particularly when there is a change in the patient’s condition or management/treatment plan
- Ask questions, listen and respond to worries and fears
- Flexible visiting appropriate to care setting
- Provision of information appropriate to care setting

Please note that text in colour and underlined are links to additional information and resources which should open automatically, however, if not, click on Windows Explorer Icon and they should appear.*
DNACPR

DNACPR Considerations for the dying patient

An objective of DNACPR policy is to encourage and facilitate open, appropriate and realistic discussions with patient/relative/carer/friend in the context of agreed goals of care. All discussions and subsequent decisions must be clearly documented.

The dying patient/relative/carer/friend -

- Should be made aware that the DNACPR decision is a clinical one because CPR is contraindicated
- Should not be burdened with feeling that they are responsible for DNACPR decision
- Should be made aware that all appropriate care and supportive treatment will continue
- If further guidance is required please refer to the DNACPR policy

SYMPTOM MANAGEMENT

1. Comprehensive symptom management guidance including medication dosing advice can be accessed at Care in last Days of Life
2. For patients with stage 4 or 5 acute or chronic kidney disease (eGFR <30ml/min), refer to the guideline Renal Disease in the Last Days of Life
3. If a patient has a symptom(s) present, then a SC bolus dose of an appropriate medicine(s) should be administered as soon as possible. If unsure please seek advice from either palliative care or pharmacy.
4. If a patient requires 3 or more SC breakthrough doses in 24 hours of any medicines, then consider the use of a continuous subcutaneous infusion(CSCI).
5. Anticipatory SC medicines should always be tailored to individual need and prescribed as suggested (Table 1).
6. If patient reaching maximum dose of as required medication or symptoms uncontrolled please seek advice from either palliative care or pharmacy.

<table>
<thead>
<tr>
<th>Table 1 ANTICIPATORY SUB CUTANEOUS MEDICATIONS INITIAL DOSE SUGGESTIONS</th>
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<tbody>
<tr>
<td><strong>Pain</strong></td>
</tr>
<tr>
<td><strong>Nausea &amp; vomiting</strong></td>
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<tr>
<td><strong>Agitation / restlessness</strong></td>
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<tr>
<td><strong>Breathlessness (dyspnnea)</strong></td>
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<td><strong>Respiratory secretions</strong></td>
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</table>

Further medication advice available from GGC Therapeutics handbook

SUPPORT AND CARE AFTER DEATH

- Support relative/carer/family. Pointers for Staff can be found on ‘Bereavement Card’.
- Bereavement booklet must be offered to relative/carer/friend - Information and Support for Relatives and Friends When Someone Has Died
- Adhere to Last Offices Protocol
- Prepare patient’s property for collection adhering to hospital/care home/hospice policy
- Inform family of need for removal of Implantable Cardiac Devices (ICD) or Pacemaker prior to cremation
- Adhere to the Verification Death policy and complete/ Medical Certificate of Cause of Death (MCCD). Arrange time and date for collection of MCCD form
- Confirm if Procurator Fiscal to be contacted, ensure this is discussed with relative/carer/family, if appropriate/possible in advance of the death.
- Inform relevant HCP of patient’s death e.g. GP, DN, Consultant, CNS

*All resources referenced in this document can be accessed at: www.palliativecareggc.org.uk/professional/eolc/

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