Care of the Patient in Terminal Phase

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Diagnosing Dying:

- Signs and Symptoms approaching death
  - Deteriorating physical function (bed bound), extensive nursing care required
  - Decreased interest in things happening around them
  - Diminished intake of food
  - Reduced ability to swallow (sips of water, unable to take oral medication)

'Active Dying'

- Progressive deterioration in the responsiveness of the patient
  - Ability to respond to surroundings, decreased energy levels, semi-comatose
- Reduced urine output
- Changes in breathing pattern
- Peripheral shut down

Goals of Care: (Communication!)

Discussion regarding change in clinical picture

- Explain rationale for changing focus of care

Discussion with the patient – determine patient wishes + goals of care

- Involve patient's Substitute Decision Maker

Complete/update Resuscitation Plan (7-Step)

Formulate plan

Review of Care Plan

Rationalisation and Deprescribing!

- Medications
- Blood tests
- Blood glucose monitoring
- Observations
- IV fluids and antibiotics
- Artificial feeds
- Blood and blood products
- Implantable cardioverter (deactivation of defibrillator)
- Mechanical Ventilation

Deprescribing Medications:

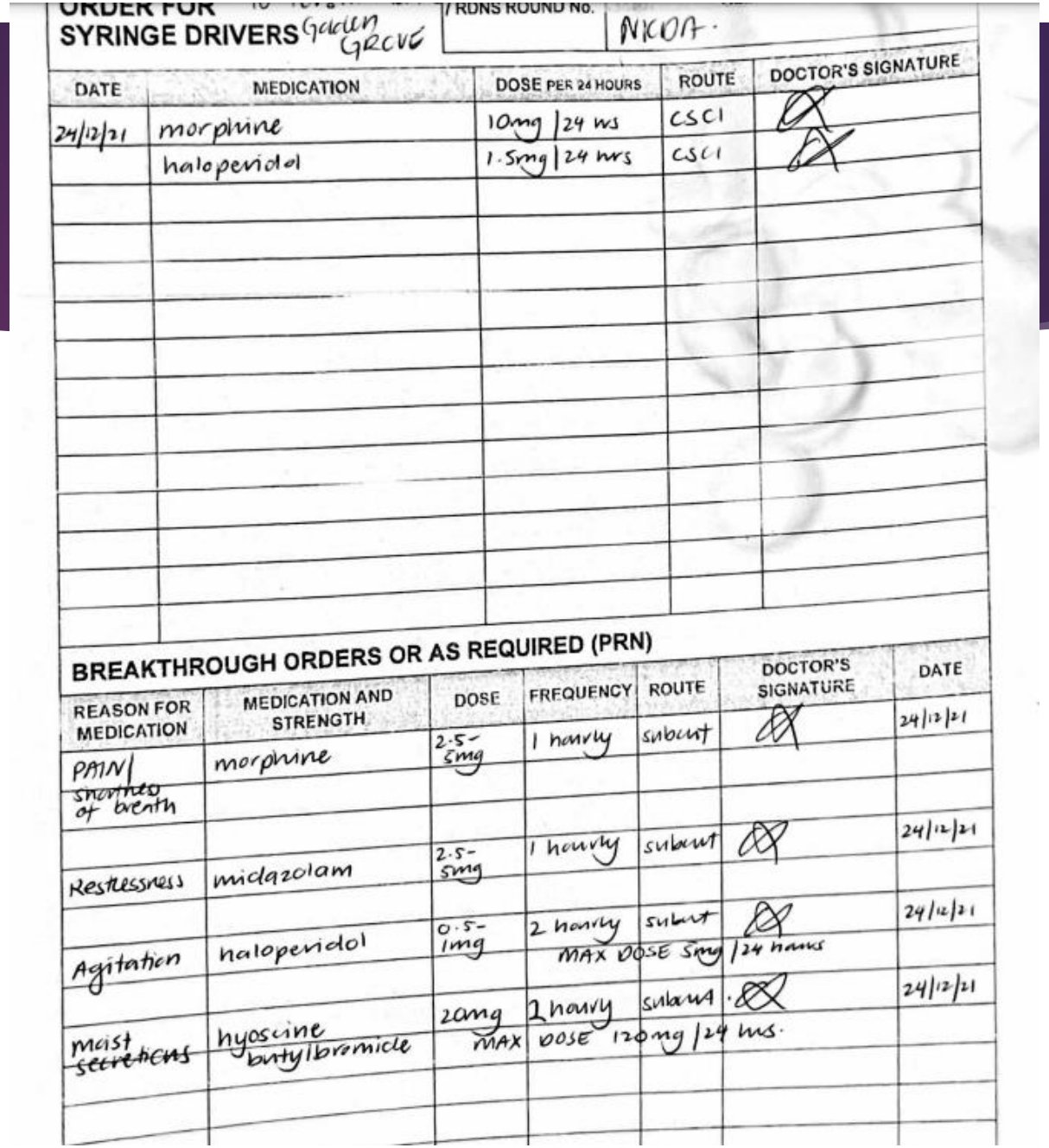
Drug Class	Symptoms Associated with Withdrawal	General Recommendations for Medication Management of Withdrawal Symptoms
Alpha-blockers	Rebound hypertension, agitation with sudden cessation	Parenteral opioid or benzodiazepine.
Anticholinergics	Anxiety, headache, dizziness	Parenteral opioid for headache or benzodiazepine for anxiety and dizziness.
	Nausea, vomiting	Parenteral antiemetic.
Anticonvulsants	Emergence or re-emergence of seizures	Continuous parenteral benzodiazepine. Seek relevant specialist advice.
Antidepressants	Dysphoric mood, agitation, headache	Parenteral opioid or benzodiazepine.
Anti-reflux medications	Heartburn, nausea.	Consider parenteral anti-reflux medication, parenteral anti-emetic and opioid.
Antiparkinsonians	Rigidity, resulting in pain	Parenteral opioid.
Benzodiazepines	Delirium, agitation, insomnia, seizures	Continuous parenteral benzodiazepine. Seek relevant specialist advice.
Beta-blockers	Rebound tachycardia, palpitations, re-emergence of angina	Parenteral opioid or benzodiazepine. Consider nitrate patch for angina.
Digoxin & other antiarrhythmics	Re-emergence of rapid atrial fibrillation or other arrhythmias, resulting in breathlessness.	Parenteral opioid or benzodiazepine.
Diuretics	Fluid retention associated with breathlessness or peripheral oedema.	Parenteral opioid or benzodiazepine.
Nitrates	Re-emergence of angina	Convert to nitrate patch. Treat symptoms with parenteral opioid.
Steroids	Hypothalamic-pituitary axis suppression in long-term use	May develop acute adrenal crisis and if concerned, seek relevant specialist advice.
	Re-emergence of painful inflammatory condition	Parenteral steroid.

Symptom Management

Symptom Management: Anticipatory Prescribing

- Pain
- Breathlessness
- Anxiety or Terminal Restlessness
- Nausea
- Moist Secretions/breathing

INDICATION	MEDICATION	DOSE	ROUTE	FREQUENCY	PRACTICE POINTS *Dosing should begin with the lower dose in any given range.*
Pain or Dyspnoea	*Morphine – pain* *Morphine - dyspnoea*	2.5mg to 5mg 1mg to 2.5mg	Subcut	every hour as required	> Doses listed are for opioid naïve patients. > Where opioids are already prescribed, convert regular oral opioid dose to the appropriate 24hour subcutaneous dose and administer by a continuous subcutaneous infusion. > HYDROmorphone is approximately **FIVE** times more potent than morphine.
	If the patient has a contraindication to morphine, for example: > ***known or suspected renal impairment, or*** > ***an allergy to morphine*** ***then give either:***				
	Fentanyl	25microgram to 50 microgram	Subcut	every hour as required	
	OR				
	HYDROmorphone	0.5mg to 1mg	Subcut	every hour as required	
Anxiety or Terminal Restlessness	*Clonazepam*	0.25mg to 0.5mg	Subcut	every 12 hours as required	> Clonazepam has a long duration of action and is pron to accumulate and lead to over sedation. > Midazolam has a very rapid onset and short duration of action. It is preferred if amnesia and sedation are required. A subcutaneous infusion is required to achieve sustained effect.
	OR				
	Midazolam	2.5mg	Subcut	every hour as required	
Delirium or Agitation	*Clonazepam*	0.25mg to 0.5mg	Subcut	every 12 hours as required	> An antipsychotic may be used as an alternative to or in addition to a benzodiazepine. > Reserve antipsychotics for patients with distressing refractory symptoms using th lowest dose possible. Refer t Clinical Guideline for advice. > Avoid haloperidol in Parkinson's Disease or if extrapyramidal side effects are distressing; olanzapine is preferred. *Seek specialist palliative care clinician advice*
	OR				
	Midazolam	2.5mg	Subcut	every hour as required	
	AND / OR				
	Haloperidol	0.5mg to 1mg	Subcut	every 2 hours prn; suggested maximum 5mg in 24 hours	
Nausea	*Metoclopramide*	10mg	Subcut	every 4 hours prn, to a maximum of 30mg in 24 hours	> Metoclopramide is contraindicated in suspected bowel obstruction > Avoid using metoclopramide and haloperidol in Parkinson' Disease or if extrapyramidal side effects are distressing; ondansetron is preferred. *Seek specialist advice.*
	OR				
	Haloperidol	0.5mg to 1mg	Subcut	every 4 hours prn; suggested maximum 5mg in 24 hours	
Gurgly / Noisy Breathing	*Hyoscine butylbromide*	20mg	Subcut	every 2-4 hours as required; maximum 120mg in 24 hours	> Start early and evaluate response. Cease therapy if ineffective after 3 consecutive doses



ORDER FOR SYRINGE DRIVERS Garden Grove

RDNS ROUND No. NKOA.

DATE	MEDICATION	DOSE PER 24 HOURS	ROUTE	DOCTOR'S SIGNATURE
24/12/21	morphine	10mg / 24 hrs	CSCI	
	haloperidol	1.5mg / 24 hrs	CSCI	

BREAKTHROUGH ORDERS OR AS REQUIRED (PRN)

REASON FOR MEDICATION	MEDICATION AND STRENGTH	DOSE	FREQUENCY	ROUTE	DOCTOR'S SIGNATURE	DATE
PAIN / shortness of breath	morphine	2.5-5mg	1 hourly	subcut		24/12/21
Restlessness	midazolam	2.5-5mg	1 hourly	subcut		24/12/21
Agitation	haloperidol	0.5-1mg	2 hourly MAX DOSE 5mg / 24 hours	subcut		24/12/21
moist secretions	hyoscine butylbromicle	20mg MAX	2 hourly DOSE 120mg / 24 hrs.	subcut		24/12/21

Pain

Opioid	Oral	Parenteral
Morphine	30 mg	10 mg (IV,SC,IM)
Oxycodone	20 mg	10 mg (IV,SC)
Hydromorphone	6 mg	1.5-2 mg (IV, SC)

Other:

- Hydration/Nutrition
- Mouth Care
- Bowel/Bladder
- Skin Care
- Wounds

Psychosocial/Cultural/Spiritual Needs

- Customs and Values
  - Importance of family/friends
  - Dying away from country of origin
  - Information that can be shared with family
    - How much information they want about prognosis
    - Communication with family - who?
  - Food and eating
- End of Life rituals
  - Last rites
  - Visits from family
  - Cermony
- Post death rituals

Post – death Plan

- Certification of death
- Death Certificate
- Funeral arrangements

?Coroners notification

Bereavement

- Limited social supports
- Developmental stage
- Family conflict
- People with mental illness/dementia/intellectual disability
- Cumulative loss
- Cause of death
  - Sudden/trauma/accident/acute deterioration
- Emotional and Physical Dependency on the patient for well being
- Guilt/shame, self blame
- Ineffective use of supports
- Feeling of loss of control