NHS
Greater Glasgow and Clyde

CLINICAL GUIDELINE

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

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Approval Group:	Medicines Utilisation Subcommittee of ADTC

Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

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

This guideline is an aid to clinical decision making and good practice. For use when there is irreversible deterioration and the clinical judgement of the multidisciplinary team is that the patient is dying and the Senior Clinician agrees with this.

Key Actions when Someone is Dying

An individualised person centred management plan has been agreed and communicated to the patient, relatives and carers. If the patient does not have capacity the plan is discussed with the Welfare Power of Attorney or Guardian.

This plan **should be reviewed and documented daily** and must include evidence of:

- Open, honest, sensitive communication, addressing any worries or concerns highlighted by patient, relatives and carers.
- DNACPR discussion and presence of form in notes.
- Discussion around what is important to the patient including preferred place of care and death, **tissue/organ donation.** If home is preferred place of care refer to **Guidance for Rapid Discharge at End of Life.**
- Discussion about plan for fluids and nutrition including the importance of mouth care.
- Ongoing **assessment and management of symptoms** including potential **Palliative care emergencies.**
- Prescribed anticipatory/just in case medications for common symptoms at end of life (see box below). Contact **Hospital Palliative Care Team** or Pharmacist for advice if required.
- Rationalisation/discontinuation of unnecessary medical, nursing and drug interventions.
- Confirmation of Death (CoD) paperwork is available where appropriate.

Review, update and communicate any changes with patient, relatives and carers at least once a day.

Key Actions at Time of and After Death

- Confirmation of Death (CoD) paperwork is completed where appropriate.
- Follow Last Offices Policy.
- Support and comfort relatives and carers and offer **mementos/keepsakes.**
- Sensitively return patient belongings using bereavement bag.
- Sensitively discuss documentation and the written information provided. **When Someone Has Died.**
- Explain Medical Certification of Cause of Death (**MCCD**) procedure.
- Community actions – arrange for equipment uplift, provide information to family regarding disposal of any drugs.

Please contact local Hospital Palliative Care Team or Hospice for Specialist Palliative Care advice/referral

Anticipatory/Just In Case (JIC) Medication

Scottish Palliative Care Guidelines Anticipatory Prescribing

Pain/Breathlessness	**Morphine Sulphate injection 2mg SC** repeated at hourly intervals as needed, If 3 or more doses are required within 4 hours with little or no benefit **seek urgent advice or review*.** If more than 6 doses are required in 24 hours **seek advice or review***. If known moderate/severe renal impairment Alfentanil is strong opioid of choice. Renal disease in last days of life Guideline
Nausea/Vomiting	**Levomepromazine 2.5mg to 5mg SC** 12 hourly as needed.
Anxiety/Distress	**Midazolam injection 2mg SC** repeated at hourly intervals as needed. If 3 or more doses are required within 4 hours with little or no benefit **seek urgent advice or review***. If more than 6 doses are required in 24 hours, **seek advice or review*.**
Respiratory Tract Secretions	**Hyoscine Butylbromide injection 20mg SC** repeated at hourly intervals as needed. If more than 6 doses are required in 24 hours, **seek advice or review*.**

***Advice or review can be sought from ward medical staff, pharmacist or Specialist Palliative Care Team**

Significant Discussion about a Patient's Care including Diagnosing Dying are made on the basis of MDT decision

- Support patient to take fluids and nutrition as long as they are able and want to. **NICE Guidance: Care of dying adults in the last days of life.**
- If subcutaneous fluids are indicated discuss and document benefits and burdens **National SC guideline** and **GGC community SC fluid policy.**
- Consider the need for a subcutaneous (SC) infusion of medication via a syringe pump - **CME T34 Guideline.**
- Discuss with patient, relatives and carers their preferences in relation to pressure area care, personal care - specifically oral, bowel and bladder care.
- Ensure all significant conversations are clearly documented.

Each Individual Patient's Physical, Psychological, Social and Spiritual needs are addressed

- It is essential to review the effect of any 'as required' medicine. This will help to direct a review of the overall treatment plan.
- Where possible and in advance identify and document any spiritual, religious, cultural needs or wishes before and after death **NHSGGC Faith and Belief Communities Manual.**
- Offer Chaplaincy or preferred faith/community leader if desired through local switchboard.
- Revisit "What Matters To Me".
- Ask patient, relatives and carers about any social or financial concerns that may need to be addressed e.g. **funeral costs/repatriation.**

Informative, Timely and Sensitive Communication is an Essential Part of each Individual Patient's Care

- Identify if patient already has an anticipatory care plan/advanced directive, living will, desire for organ/tissue donation and revisit sensitively.
- Patient, relatives and carers are kept up to date, regularly asked what is important to them and if they have any worries or concerns.
- Identify any communication barriers and request support e.g. from **interpreters**.
- If Procurator Fiscal involvement will be required discuss this with relatives and carers sensitively.
- Where relevant update KIS/ACP.

Consideration is given to wellbeing of Relatives and Carers attending the Patient

- Keep relatives and carers updated especially as patient deteriorates.
- Ask relatives and carers how we can support them.
- Offer written information if desired – **What Can Happen When Someone is Dying booklet.**
- Provide information about visiting, car parking and catering.
- If relatives and carers are identified to be at risk of complicated grief, with permission refer to relevant General Practitioner/ Health Care Professional.

The 4 statement headings above are drawn from
Caring for people in the last days and hours of life – NHS Scotland 2014