MIL Oxford University Hospitals NHS Trust

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This Medicines Information Leaflet is produced locally to optimise the use of medicines by encouraging prescribing that is safe, clinically appropriate and cost-effective to the NHS.

Decision Making for End of Life Care in the Dying Patient (Adult)

Prognosis of the exact time of death in a patient at end of life (EoL) is extremely difficult. It is easier to talk in terms of weeks or days depending on whether the rate the patient is deteriorating can be measured in weeks or days. The signs and symptoms that the patient may only have a few days to live are:

- profound weakness and bedbound,
- drowsy or reduced cognition,
- taking only sips of fluid,
- difficulty in swallowing medication,
- reversible causes have been excluded or declined by the patient,
- as expected with the disease trajectory.

Be aware of any advance care plans the patient may have for this eventuality.

- Discontinue inappropriate medical and nursing interventions such as blood tests, IVIs and observational monitoring.
- Ensure plans for regular mouthcare[2],
- Plan rectal interventions every 3 days if the patient will tolerate this,
- Support the patient and family/carers as appropriate to ensure that they know what is happening and understand the management plan.
- Complete a DNACPR (do not attempt resuscitation) if not already in place, having discussed and communicated with the patient, family and multidisciplinary team. Document in the patient's record on EPR.

The goals for the last 24 hours are to ensure that the patient is comfortable physically, emotionally and spiritually.

Medication review

Review all medication and deprescribe as appropriate considering prognosis and availability of the oral route or not, stopping all medications for secondary prevention and non-essentials.

Diabetes: stop oral antidiabetics. Consider converting insulin regimes to long acting insulin. Monitor a daily CBG (capillary blood glucose) in the morning. Aim for a CBG of 8-20mmol/l. [1]

Renal impairment: in patients with moderate to severe renal impairment eGFR less than 30ml/min, continue diuretics for symptom management until the oral route is lost. Consider choice of drugs for symptom management in view of renal impairment.

Heart failure: continue diuretics, digoxin/beta-blockers in atrial fibrillation until the oral route is lost. Review antianginal medication once the patient is bed bound.

Parkinson's disease: consider levodopa replacement with transdermal rotigotine[3] and avoid dopamine antagonists e.g. metoclopramide, haloperidol etc for symptom management.

Symptoms at EoL

The commonest symptoms experienced at EoL are:

- pain
- nausea and vomiting
- delirium
- respiratory secretions

The pharmacological management of these symptoms at end of life is detailed in the accompanying MIL[4]. Even if the patient is initially not experiencing any of these symptoms, a range of anticipatory subcutaneous medicines prescribed on the "as required" side of the medicine chart is good practice. If the patient needs regular medication for symptom control then a syringe driver[5] can be set up to deliver a 24 hour continuous subcutaneous infusion (CSCI). This should be individualised to the patient and their symptom management needs. Remember to continue the anticipatory PRNs prescribed alongside the CSCI, individualised to the patient's symptoms and the syringe driver prescription. Review the CSCI at least daily and adjust to the patient's response taking account of any PRNs used over the previous 24 hours. Check with Pharmacy or Palliative Care for compatibility of medicines within a syringe driver[6]. There are PowerPlans available on EPR for anticipatory prescribing and syringe drivers for symptom management at end of life to guide prescribing.

Hydration and nutrition

Current best evidence is that there is no benefit from artificial hydration at the end of life and potential harm. Good regular mouthcare and sips of fluid, if requested and tolerated by the patient, are usually sufficient at this stage to maintain comfort. This may need careful explanation to families. Current best evidence is that artificial feeding at the end of life will not prolong life or enhance its quality. It is a normal part of dying to reduce oral intake of food and fluids.

Useful documents:

1. Management of diabetes in the last days of life.
2. Management of Oral Symptoms
3. MIL: Guidelines for the use of Parkinson's medications in patients.
4. MIL: Symptom management for palliative and end of life patients (Adult) using the subcutaneous route.
5. OUH T34 syringe driver guidelines.
6. OUH Preparation of syringe driver combinations

Additional references

- Twycross R., Wilcock A., Palliative Care Formulary 6th ed. 2016 palliativedrugs.com
- Twycross R., Wilcock A., Introducing Palliative Care 5th ed. 2016 palliativedrugs.com
- NICE NG31 Care of Dying Adults in the Last Days of Life 2015

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