University Hospitals of North Midlands NHS
NHS Trust

Principles of care in last days of life on Critical Care Unit

- The named Critical Care consultant should lead the diagnosis that the patient is dying in consultation with the MDT after consideration of reversible causes.

- Inform the family that their relative is thought to be dying and of the plan of care. This must be documented in the medical notes

- Assess all interventions and document a plan for which should continue and which should be stopped. Interventions should only continue if they will improve comfort or will affect the management plan.
  o Review all medications
  o Review the need for testing and monitoring e.g. blood testing, ABGs, nursing observations, continuous monitoring, imaging
  o Review the plan for artificial hydration and nutrition
  o Review resuscitation status
  o If the patient has an ICD document a plan for preventing peri-death shocks being administered

- Document a plan for whether there should or should not be any escalation of treatment e.g. should new interventions be commenced in any circumstances

- Anticipatory prescribing of as required medications for **all** patients both IV and SC
  o Midazolam 2.5-5mg prn for agitation or dyspnoea
  o Hyoscine butylbromide 20mg prn for respiratory secretions
  o Haloperidol 1.5-3mg prn for nausea and vomiting
  o Morphine 2.5-5mg prn for pain or dyspnoea for patients not taking regular opioids and with eGFR over 50 when last checked
  o An alternative opioid or dose may be required for patients with significant renal impairment or patients who are already taking strong opioids. Advice can be obtained from the Hospital Palliative Care Team 9-5 on extension 74029 or the DMH 24 hour advice line Tel 344300

- If the patient is symptomatic a continuous infusion of medication may be required. Contact the Palliative Care Team if advice needed.

- Ensure that patient and family are supported
  o They may require emotional support
  o If the family wish to stay outside visiting hours this should be facilitated
  o Make sure that spiritual needs are met and chaplaincy referral is offered

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V1 July 2016

Transfer of dying patients from Critical Care Unit

- Consider carefully whether the patient is likely to survive the transfer to a ward and whether it is likely to cause distress to the patient or family

- Inform the family that the patient will be transferred, when this will happen, who will accompany them and whether a family member can accompany them during transfer

- Remove all continuous monitoring

- Remove central lines, arterial lines and any intravenous cannulae that are not in use

- Patients should not be transferred to wards with IV infusions of anaesthetic or inotropic drugs. These should be fully withdrawn prior to transfer

- Most wards are not able to care for patients with tracheostomies. If decannulation is planned, this should be done at least 1-2 hours before transfer to a ward so that the patient can be reacnnulated if they become very distressed. If the patient has a long term tracheostomy, they should not be decannulated

- Patients should not be transferred to wards with IV infusions of symptom control medications such as opioids or benzodiazepines
    - These should be changed to a SC infusion
    - This can be set up in an Aseena or Alaris pump (in use in Critical Care) via a SC butterfly needle
    - A blue or orange butterfly can be placed in the upper arms, thighs or abdominal wall (avoid broken, inflamed or oedematous skin) and covered with a transparent dressing such as Tegaderm
    - In general a IV:SC dose ratio of 1:1 should be used for drugs used to control symptoms
    - However, if high doses of opioids or benzodiazepines (over 100mg per 24 hours of morphine, midazolam or equivalent) are prescribed for please consider whether symptoms are present that warrant this dose and whether the dose can be reduced
    - Diazepam should not be given by the SC route and if a benzodiazepine is required Midazolam should be prescibed
    - When a SC infusion is started to replace an IV infusion, the IV infusion should be continued for 1-2 hours to ensure symptom control is maintained
    - The infusion should be prescribed on a hospital prescription chart in the infusion section
    - The infusion should be made up to 24ml with water for injection and run at 1ml/hr SC

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- Ensure that the DNAR form accompanies the patient during transfer

- Ensure that as required medication for symptom control (see above) is prescribed on a hospital prescription chart by the subcutaneous route

- Ensure a verbal handover has been given to the ward team taking over care

- It is helpful to write a summary any important decisions and the plan of care in the medical notes as the Critical Care patient record may not be available or accessed once the patient is on a ward

- Please refer all patients who are in the last hours or days of life who are being transferred from Critical Care to the Hospital Palliative Care Team by completing an Ordercomm