The Doctors' Handbook

You've Been **Bleeped:**

The dying patient

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Introduction

- The average FY1 will have 40 patients who will die whilst under their care
- They will also meet 120 patients who are in their last year of life
- Palliative care is a relatively new specialty, and as such is commonly misunderstood by other specialties

Introduction

The system frequently fails to:

1. **Recognise** patients who are in their last few months of life, and who would benefit from a discussion with the palliative care team to avoid unnecessary interventions
2. **Appropriately** manage patients who are in their final days of life

Introduction

As a FY1, you can have a **huge** impact on patients and their families through understanding the basics of palliative care, and by acting as an advocate

You've Been **Bleeped:** Scenario 1a

- You're the FY1 on a Care of the Elderly ward
- Very unwell patient, multiple comorbidities
- No capacity for major decision making at this time
- Consultant decides to put in place a DNACPR
- They sign it, then leave the family discussion to you

Scenario 1a

1. **Location** of family discussion?
2. **Who** can you bring with you?
3. How would you **explain** what a DNACPR is?
4. What are the **benefits** of a DNACPR?
5. What can you **reassure** the family of? What might they be **fearful/confused** over?

Scenario 1a

1. Ensure the discussion happens somewhere quiet and **private**
2. Bring the **nurse** looking after the patient
3. Explain that if their heart stops, we won't push on the chest or deliver electric shocks
4. This is because it likely wouldn't work and would only cause them pain. Emphasise '**comfort**' and '**dignity**'
5. It is not 'giving up'. They can still receive **active treatment** e.g. IV Abx

You've Been **Bleeped:** Scenario 1b

Same scenario as before, but this time the patient has severe Parkinson's disease

They can barely move or speak, and are currently being treated for aspiration pneumonia secondary to an unsafe swallow

How do you approach it **now**?

Scenario 1b

Assess their capacity. Support them with any communication difficulties

Have the same meeting but by the patients' bedside, curtains drawn with a nursing colleague present as before

NB It is very easy for these patients to have their wishes side-lined by well intentioned family/clinicians

You've Been **Bleeped:** Scenario 1c

You are the weekend ward-cover on-call FY1. Your bleep goes off to attend a 2222 peri-arrest call. You are the first to arrive and you don't know the patient

As you arrive, one of the HCAs says 'oh wait, I shouldn't have put out the peri-arrest call, they've got a DNACPR form

What do you **do**?

Scenario 1c

- A-E assessment as normal
- DNACPR isn't **legally binding**. It's advisory based on the team looking after the patient
- Each clinician still has to make their own decision based on the specifics of the situation
- If there is a new, reversible problem e.g. choking on a foreign body / anaphylaxis, then a 2222 peri-arrest would be appropriate, depending on the parameters of the DNACPR

You've Been **Bleeped:** Scenario 2a

- 86F, very unwell, multiple comorbidities
- Already has a DNACPR
- Has not responded to treatment
- Consultant decides to withdraw active treatment and give palliative medications to make her comfortable for her last few days

You've Been **Bleeped:** Scenario 2a

You are asked to write up the Anticipatory medications for her last few days including analgesia

Weight	89kg
eGFR	57

Scenario 2a

King's protocol

NB: Follow your own local guidelines

Morphine 2mg subcut PRN	up to 1 hourly for pain
Morphine 1mg subcut PRN	up to 1 hourly for SOB
Midazolam 2mg subcut PRN	up to 1 hourly for agitation
Glycopyrronium 200mcg subcut PRN	up to 4-6 hourly for respiratory secretions
Haloperidol 500mcg subcut	up to 8 hourly for nausea

Scenario 2a

Titrate according to response

If more than 2-3 doses required in 24 hours then consider a syringe driver for **continuous subcut infusion** (CSCI)

Contact Palliative care for guidance on the syringe driver

You've Been **Bleeped:** Scenario 2b

Same scenario as before but

Weight	52kg
eGFR	29

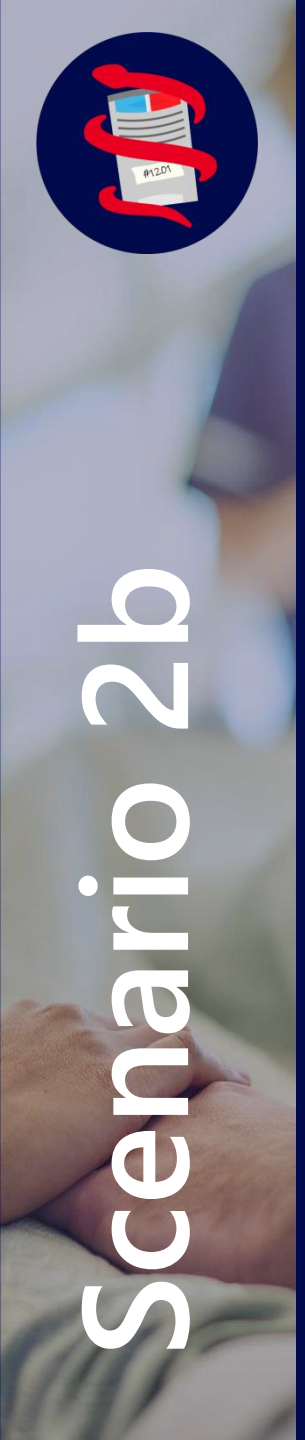
Scenario 2b

King's protocol for eGFR <30 or liver failure

NB: Follow your own local guidelines

Fentanyl 25mcg subcut PRN	up to 1 hourly for pain
Fentanyl 12.5mcg subcut PRN	up to 1 hourly for SOB
Midazolam 1mg subcut PRN	up to 1 hourly for agitation
Glycopyrronium 200mcg subcut PRN	up to 4-6 hourly for respiratory secretions
Haloperidol 500mcg subcut PRN	up to 8 hourly for nausea

If more than 2-3 doses required within 24 hours
then consider syringe driver



Scenario 2b

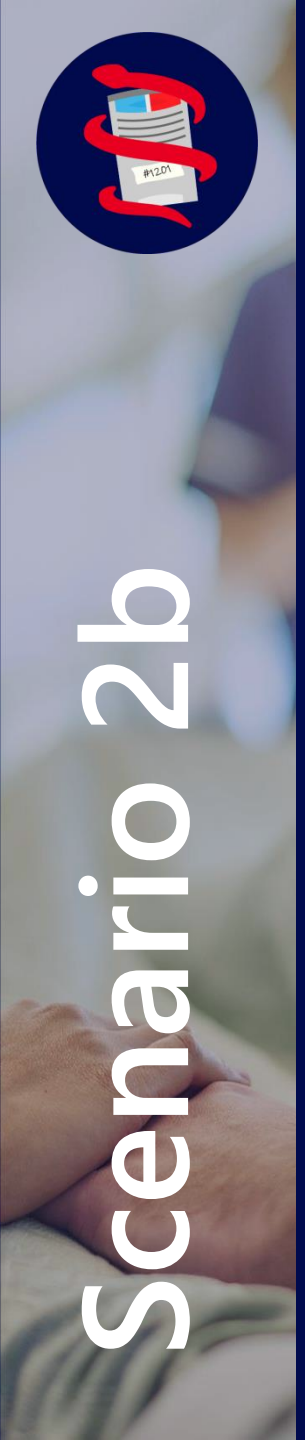
In very rare circumstances, you may need to give naloxone

In the instance of a patient in the last few days, what **dose** should you give?

50mcg – not 200-400mcg as routinely prescribed for opiate overdose.

The reason for the lower dose is because waking up suddenly in severe pain can **hasten** their death. We can still give repeated doses if necessary.

NB Only use in rare circumstances if you perceive that the opiate toxicity is causing faster deterioration than the illness.



Scenario 2b

How do we **monitor** for opiate overdose if we've stopped clinical observations including RR and SpO_2?

Scenario 2b

As long as you only **titrate** opioids up from low doses by accurately monitoring the response of the symptoms to each dose, then the risk of causing an overdose is **extremely small**

Even once observations have been stopped, it's still important to **regularly review** the patient in order to ensure they are able to die peacefully

Diagnosing the dying patient

Download the 2 page Gold Standards Framework Proactive Identification Guidance and **save to your phone:** www.goldstandardsframework.org.uk/PIG

The Surprise question:

'Would you be **surprised** if the patient were to die in the next year, months, weeks, days?'

If the answer is 'no' then move onto step 2

Step 2 – general indicators of decline

General physical decline, increasing dependence and need for support

Advanced disease - unstable, deteriorating, complex symptom burden

Presence of significant multi-morbidities

Repeated unplanned hospital admissions

Decreasing activity – functional performance status declining (e.g. Barthel score) limited self-care, in bed or chair 50% of day and increasing dependence in most activities of daily living

Decreasing response to treatments, decreasing reversibility

Patient choice for no further active treatment and focus on quality of life

Sentinel Event e.g. serious fall, bereavement, transfer to nursing home

Serum albumin <25g/L

Progressive weight loss (>10%) in past six months

Considered eligible for DS1500 payment

You've Been **Bleeped:** Scenario 3

74M admitted with acute exacerbation of CCF. You note that this is his 3rd admission within the last 6 months

Baseline function: breathless at rest

You've Been **Bleeped:** Scenario 3

On admission

HR 101 | **97** 68

RR 28 | 95% on optiflow

T° 36.5

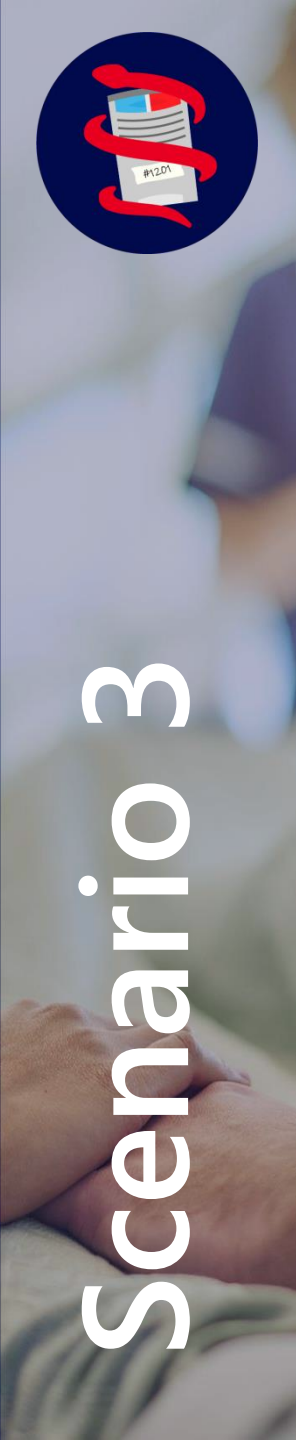
After 2 days of optimal treatment with furosemide, O_2 and nitrates

HR 95 | **105** 62

RR 26 | 94% on optiflow

T° 36.5

Which are the key features indicating a **poor prognosis** according to the Gold Standards Framework?



Scenario 3

Key features of decline for this patient (2 or more qualify):

- **Repeated admissions** with heart failure – 3 admissions in 6 months or a single admission aged over 75 (50% 1yr mortality)
- Difficult ongoing physical or psychological symptoms **despite** optimal tolerated therapy

You've Been **Bleeped:** Scenario 4

53F admitted with a CAP

PMHx alcoholic liver disease with liver sclerosis and ascites

On examination, abdomen distended ++, lethargic, enceophalopathic

You've Been **Bleeped:** Scenario 4

Bloods

Albumin	15
INR	2.3
WBC	19
CRP	210

She had a previous admission for a CAP 2 months ago, with a sputum culture showing sensitivity to co-amoxiclav

On this occasion, despite 2 days of co-amoxiclav, her observations and inflammatory markers have remained largely static.

Scenario 4

Key features of decline for this patient involve advanced cirrhosis with complications including:

- Refractory ascites
- Encephalopathy
- Malnutrition
- Bacterial infection
- Raised INR

Advanced Care Plan

What might this **cover**?

NB: timeline of last few months/years

Considers:

- Hospital re-admission vs community care
- IV fluids
- IV Abx vs oral Abx
- Nutrition – PEG/NG/oral/feed at risk
- DNACPR and ITU admission

Communicating Advanced Care Plans

Each ACP should be **personalised** after discussion with patient and family

Explain that after a certain point, repeated hospital admissions can do **more harm** than good

- Patients often vulnerable with dementia/delirium
- Admitted into unfamiliar environment with unfamiliar staff
- Lots of bright neon lights and stabbed repeatedly with needles

Emphasise that in many cases, ACPs still involve **active treatment** like Abx

Benefits of ACPs

- When a patients condition changes, relatives are often left unsure what sure to do and so phone 999
- This results in many palliative patients' coming to A&E for whom hospital admission is not appropriate
- Often the family are very grateful for the chance to avoid further re-admissions; they just want a plan so they know what to do in case things change

End of Life Plans

- You are on a Care of the Elderly Ward. An End of Life decision has been made by the consultant and they have communicated this to the family
- The patient is expected to die within the next few days
- You have been asked to discuss the End of Life plan with the patient and family

What might this **cover**?

NB: timeline of last few days/weeks

Considers:

- Religious beliefs and need for a chaplain/other religious figure
- DNACPR
- IV fluids / PO fluids
- Nutrition
- Would they like to stay in hospital, go to a hospice or plan to die at home?

Verifying a death

Go from top to toe

- No **verbal** response
- **Pupils** unreactive to light
- No **carotid pulse** palpable 1 minute
- No response to **sternal rub**
- No **heart sounds** heard, 2 x places 1 minute each
- **Pacemaker** palpated/not palpated
- No **breath sounds** heard, 2 x places 1 minute each

Death confirmed at X time on Y date
Dr J Bloggs
Signature

Misconceptions around palliative care

- Palliative care does not necessarily mean ‘last days’. It just means **irreversible decline**, they could have >1 year of life left
- A DNACPR form is **not** a reason to withdraw active treatment
- Active treatment and End of Life/last few days care should not be blurred
- Palliative patients **can** be given Abx in certain circumstances

Take home message:

If you are ever unsure about an aspect of palliative care or an End of Life decision, contact the **palliative team** for advice.

All patients should be referred anyway, but they can clarify/correct/challenge incorrect decisions made by senior members of the team if you do not feel comfortable to do so.

Feedback

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