Guidelines on Symptom Control at End of Life in an Acute Hospital

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Background

Many patients die in acute hospitals under the care of clinical teams and may or may not require specialist palliative care input. Current Medical Council recommendations in Ireland advise that doctors should treat patients who are dying with dignity, optimize comfort and it recognises family's communication needs. These guidelines were developed as part of an audit of symptom control of patients at the end of life in an acute hospital.

Aims and Objectives

The aim was to create guidelines to facilitate symptom management and care planning for patients who are imminently dying. The intent was to empower non-palliative care medical practitioners in their clinical decision making.

Conclusion

The guidelines were developed to aid effective, appropriate symptom control of patients who are imminently dying and to guide non-palliative medical practitioners in managing their care. They advise on medication management; clinical practice and communication issues to assist in formulating an individualised, patient-centered care plan for patients who are imminently dying.

Methods

A collaborative, interdisciplinary, interdepartmental process was involved in developing the guidelines. They were developed based on current evidence, palliative care practice, and feedback from the consultative process.

Results

The guidelines consist of prompts to aid individualised, patient-centered, clinical decision making. They include addressing reversible causes of deterioration, if appropriate and consideration of the ceiling of care. There are recommendations for anticipatory medications; addressing the environmental setting and communication. Specialist palliative care advice and involvement can be sought at any stage of management.

Anticipatory Medications

Pain
- Not already on opioid: start Morphine Sulphate 2.5mg 2-hourly PRN SC
- If eGFR ≤ 10mmol/min: use 1.25-2.5mg morphine sulphate 2-hourly PRN S/C
- OR Oxycodone 1.25-2.5mg 2-hourly PRN SC
- Already on an opioid, break through is 1/6th off total daily opioid

Nausea and Vomiting
- Cyclizine 50mg TDS/PRN SC
- Haloperidol 0.5-1.5mg TDS PRN SC
- Levomepromazine 6.25mg QID/PRN SC (avoid if history of siezures)

Anxiety/Agitation
- Midazolam starting dose 2.5mg 2-hourly PRN SC
- Terminal Agitation: Midazolam 2.5-5mg 2-hourly PRN SC or Levomepromazine 6.25mg-12.5mg QID/PRN SC (avoid if history of siezures)

Respiratory Secretions
- Glycopyrrolate 400mcg 4-hourly PRN SC
- Hyoscine Butylbromide 20mg QID/PRN SC
- Hyoscine Hydrobromide 400-600mcg QID/PRN SC (causes sedation)
- * If patient has known pulmonary oedema use Furosemide 20-40mg SC BD/PRN

Dyspnea
- 1st line use opioid
- 2nd line use benzodiazapine
- *in extreme breathless ness consider opioid and benzodiazepine concomitantly

Ceiling of Care and Environmental Settings

Ceiling of Care
- Include patient and family in care planning;
- Clarify and record resuscitation status;
- Consider if further IV cannulation or bloods are appropriate;
- Review drug kardex and stop unnecessary medications;
- Does the patient need medications by SC infusion via syringe driver

Settings
- Transfer to a Solas room and record in medical notes
- In ED, move patient from a trolley to a bed in an area with the most appropriate available environment