End of Life Care Principles and Management

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“How people die remains in the memory of those who live on…..”

- Dame Cicely Mary Saunders
Outline the session

- How do we define the EOLC?
- What is best practice end of life care?
- What is needed to support this?
- What is your understanding about ‘Place of Care’ in EOLC?
- What are the Common Physiological Changes in EOLC?
- What are the main distressing symptoms in EOLC?
- How do we manage these symptoms?
How do we define ‘EOLC’?

The management of patients during last few days, weeks or month of their life, from a point when it becomes clear that the patient is in a progressive state of decline.
What is best practice end of life care?

**Step 1**
Discussions as the end of life approaches
- Open, honest communication
- Identifying triggers for discussion

**Step 2**
Assessment, care planning and review
- Agreed care plan and regular review of needs and preferences
- Assessing needs of carers

**Step 3**
Coordination of care
- Strategic coordination
- Coordination of individual patient care
- Rapid response services - GP Assist - CNs - PCS advice

**Step 4**
Delivery of high quality services in different settings
- High quality care provision in all settings
- Acute Hospitals, Community, Care homes, Hospices and Other in-patient facilities
- Ambulance Services

**Step 5**
Care in the last days of life
- Identification of the dying phase
- Review of needs and preferences for place of death
- Support for both patient and carer
- Recognition of wishes regarding resuscitation and organ donation

**Step 6**
Care after death
- Recognition that end of life care does not stop at the point of death.
- Timely verification and certification of death or referral to coroner
- Care and support of carer and family, including emotional and practical bereavement support

**Support for carers and families**

**Information for patients and carers**

**Spiritual care services**
What is best practice end of life care? & The ideal EOLC pathway is:

- Patients’ Preferred Place for Care & Death (PPoC and PPoD)
- Goals of Care (GoC)
- End of Life Care Pathway (EOLC)
Advance Care Planning

Process:

- The process is voluntary
- The content of any discussion should be determined by the individual concerned
What is your understanding about ‘Place of Care’ in EOLC?

- Patient Preferred Place of Care
- Patient Preferred Place of Death

Most people would prefer to die at home

Some want to be at health care setting: Hospital or N-Home for safety! ("feeling safe")

Some want to die at home but end up @ acute hospital ("Unable to cope" or "distressing Symptom issues")
Patient Preferred Priorities for Care
[ Preferred Place of Care (PPoC) / Preferred place of Death (PPoD) ]

What is it?

- An advance care plan for people with a life limiting illness who wish to have their choices and preferences recorded in relation to their care and ultimate place of death

- A patient held record which should go with the patient if they are transferred to a different care setting
Positives of Implementing patient priorities of care

- Empowering for patients ("I’m still in control" & every thing happening according to my wish")
- Opens up vital discussions
- Promotes choice
- Excellent way of lobbying for further resources
- Helps prevent inappropriate transfer to another setting.
- Builds staff confidence and encourages difficult conversations

Support to the staff
- Not everyone finds it easy to have conversations about death and dying
- Staff may need additional support through communication skills training or through mentor or peer support
What are the Common Physiological Changes in EOLC?

• Weakness / Fatigue
• Decreasing Appetite / Food intake / Wasting
• Decreasing Fluid intake / Dehydration
• Decreasing Blood Perfusion / Renal Failure
• Neurological dysfunction
• Decreasing Level of Consciousness
• Terminal Delirium
• Changes in Respiration
• Loss of ability to swallow
• Pain
• Loss of Ability to close the eyes
What are the main distressing symptoms for patients and family/carers in EOLC?

- Holistic, total care – Not only to the patient but also to family.
- All the distressing symptoms need to be addressed to provide comfort/supportive care.

Main Distressing symptoms are:

1. Pain
2. Agitation / anxiety / SOB
3. Nausea
4. Excessive Chest secretions
How do we manage these symptoms?

Pain management in end of life care

- Pain is a symptom that can occur or increase at the end of life.
- Where pain is a pre-existing symptom, measures should be in place to ensure continued effective management during the end of life.
- If pain is not a present problem, an intermittent (PRN) analgesic is ordered in anticipation of pain presenting.
- The end of life goal is that the individual be pain free.
- Regular assessment is needed.
- When pain is assessed, ordered analgesia is administered, and effectiveness determined.
- Episodes of pain and its management are documented.
If more than 3 PRN doses are given in a 24-hour period:

- regular subcutaneous administration 4 hourly or a continuous subcutaneous infusion via syringe driver may be considered.

- if already on regular administration the dosage should be reviewed

- the PRN order is reviewed in line with alterations to regular doses
Other Pain Management Issues

• Keep the individual and/or their primary carer informed about the care strategy

• Ensure that PRN medications are given in response to pain, or in anticipation of incident pain (e.g.: on moving)

• Ensure that the attending doctor is informed of any inadequacies in the pain management strategy

• Remember that any pain experience can be amplified by psychological and spiritual distress

• Maintaining general comfort measures will contribute to the overall management of pain
SOB / Anxiety / Agitation

• Low dose regular opioid

• Anxiolytics – Short acting ‘pams’ are helpful (Oxazepam, Lorazepam)

• These drugs can break SOB → Anxiety cycle

• Non – Pharmacological interventions (fan)

• ? Oxygen- no much research evidence

• If less responsive, unable to take orally (Drowsy but agitated a lot)
  ➔ Midazolam inj sc or via S/driver over 24 hours
  ➔ 2nd line: Levomepromazine via S/driver 12.5 -25mg over 24h
  ➔ 3rd line: Phenobarbital infusion
Death Rattle / Excessive Secretions

- Why secretions are more pronounced in terminally ill patients?
- Medications Glycopyrronium / Hyoscine
- Dose?
  - Glycopyrronium 0.2-0.4mg sc stats (max of 2mg/24hr) or SD start with 600mcg – 1.2 mg/24hr
- # Hyoscine: Buscopan 20mg sc stats (max 240mg/24h)
  - or SD-Buscopan 60-240mg/24 hr
# Nausea / Vomiting

Many causes & it can be multifactorial

**Approach:** (1) mechanistic or (2) empirical

**What is Mechanistic approach?**  
- Accurate identification of the cause  
- Understanding of pharmacological mechanism  
- Use of most effective drug

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<thead>
<tr>
<th>Drug</th>
<th>Mechanism</th>
<th>Indications</th>
<th>Dosage</th>
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<tbody>
<tr>
<td>Metoclopramide</td>
<td>D₂ Antagonist, 5HT₃ at high doses + (5HT₄ - gut)</td>
<td>For Prokinetic Activity (Gastric stasis)</td>
<td>10-20mg qid</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>D₂ Antagonist</td>
<td>For Biochemical Causes (Hypercalcaemia, RF)</td>
<td>1.5mg nocte 6mg/24 hr</td>
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<tr>
<td>Cyclizine</td>
<td>H₁ Antagonist, Anticholinergic antagonist</td>
<td>For Central Causes (Increased ICP)</td>
<td>50mg tds</td>
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<tr>
<td>Levomepromazine</td>
<td>D₂ + H₁ + 5HT₂ Antagonist + Acetylcholine</td>
<td>Std 2&lt;sup&gt;nd&lt;/sup&gt; due to its multiple receptor activity</td>
<td>6.25mg 25mg/24hr</td>
</tr>
<tr>
<td>Ondansetron</td>
<td>5HT₃ Antagonist</td>
<td>Chemo / DXT related Nausea</td>
<td>4mg tds or 8mg bd</td>
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<tr>
<td>Others: PPI / Lorazepam / Steroid</td>
<td>PPI → Reflex disease associated N Lorazepam → anxiety induced N/V Steroid→ Combination in Chronic N</td>
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Issues around Commencing SD in the Community

- The drug compatibility
- Consider whether prescribed doses are exceeding the maximum volume of the SD?
- SD site issues
Review

- If the prescribed medications are ineffective a medical review is indicated.

- Escalating doses of opioids, Benzodiazepines or anti-emetics are not commonly seen in the last days of life, and should be regarded as an indication for urgent medical review.

- Consult with the specialist palliative care service if indicated.
The Key Tasks or ‘7 Cs’

- Communication
- Co-ordination
- Control of symptoms
- Continuity out of hours
- Continued learning
- Carer support
- Care of the dying
End of Life Care is About......

- Planning ahead for end of life care journey....
  
  Have you seen the pilots checking ‘every thing’ in the cockpit, before they fly?

- ‘Anticipatory care’ helps to avoid crisis and it can provide support for families and nursing teams, reduce unnecessary hospital admissions and give satisfaction to the patient of ‘being in control’ (preferred place of care/death)
Thank You