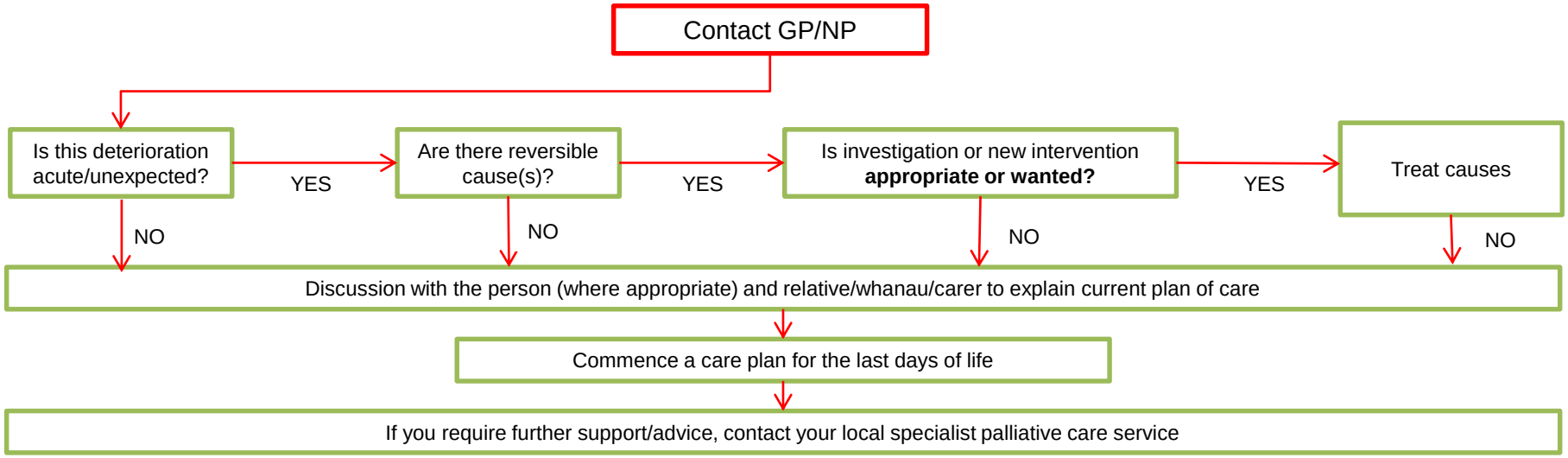
Last days of life – recognising dying

Recognition of deterioration – contact GP/NP/family/whānau

Assessment

Two or more of the following (new signs/symptoms) may apply	
Profound weakness or bed bound	The person is semi-comatose/unconscious
No longer able to swallow tablets	Only able to take sips of fluids
The person is peripherally shut down	Unable/unsafe to swallow any fluids
Person, family or whānau state they are dying	



Commence a care plan for the last days of life

1. Family/whānau notified (if not already) of person's condition. Offer family/whānau involvement in care and allow them to stay over
2. Psychological support: plan of care discussed with person (if appropriate) and family/whānau
3. Spiritual/religious/cultural beliefs: addressed with person and family/ whanau – facilitate any identified rituals around death and dying
4. Medication: non-essential medication discontinued, anticipatory prescribing done
5. Discontinue inappropriate interventions: eg, antibiotics, blood tests, vital signs monitoring. Ensure 'allow for natural death' – 'not for resus' documented
6. All assessment, planning and discussion clearly documented. Note: refer to organisational policy/Ministry of Health Te Ara Whakapiri (2017)

Assessment and management of symptoms

General principles

- Ongoing holistic assessment of the person (physical, social, cultural, psychological and spiritual) utilising appropriate assessment tools where possible
- Clearly documented plan of care, care provided and any conversations you have had with the person, their family/whānau and colleagues
- Assess effectiveness of interventions
- Ensure medicines are prescribed in anticipation of symptoms occurring eg, analgesia, anxiolytics, anti-emetics
- Decreased consciousness and/or an inability to swallow is common in persons who are in their last days of life. Ensure medication is prescribed for subcutaneous administration in anticipation
- Ensure the person (if possible) and their family/whānau receive appropriate information and reassurance about each symptom and the plan of management
- If symptoms are not adequately managed, the person requires a medical/NP review
- If a symptom persists, contact a specialist palliative care service, eg, hospice, hospital palliative care team

Pain

- When pain is pre-existing symptoms, continue with prescribed medication and use an appropriate route
- Utilise an appropriate pain assessment tool, eg, Abbe4y Pain Assessment Tool
- Involve the family/whānau in the assessment process – they may have insights into pain behaviour
- Right medication for the pain type
- Provide the person with analgesia prior to providing an intervention which may cause pain, eg, turning
- Reposition the person regularly to reduce pain from pressure and muscle contractures (refer to your organisational policy re: frequency of repositioning in last days of life)

Nausea and vomiting

- If the person has required regular anti-emetics, consider prescribing medication via a continuous subcutaneous infusion
- Non-pharmacological interventions include the following: management of odour, fresh air, positioning, might be important to reduce blankets/heavy hot clothing, use of complementary therapies
- Ensure the person receives excellent mouth care at least four-hourly

Shortness of breath (SOB)

- When SOB is a pre-existing condition and the person has required low-dose opioids and/or benzodiazepines for its management, continue use of this medication via an alternative route, eg, continuous subcutaneous infusion – CSCI
- If SOB is a new symptom, ensure PRN medication is prescribed, eg, low-dose opioid + or – a benzodiazepine, eg, midazolam
- Provide information, reassurance and a calm presence to the person and their family/whānau as SOB can be very frightening
- Use a cool fan or open window to assist with air movement across the face
- Oxygen is not usually indicated or helpful unless it is part of the person's ongoing management
- Position the person in a way which eases their SOB; most people who are breathless prefer to be sitting slightly upright

Respiratory secretions during last days of life

- This sound can be a source of distress for family/whānau and caregivers
- Support with reassurance and a calm presence
- Be consistent with explanations about the cause and effect of 'respiratory secretions' (see last days of life care plan supporting documentation) and alleviate family/whānau concerns that the symptom is not causing distress to the dying person
- Provide distraction from the sound, eg, background music
- Ensure excellent mouth care and encourage family/whānau to be involved
- Often repositioning the person side to side with the head of the bed slightly elevated helps to shift secretions and reduce the noise
- Anticholinergics, eg, hyoscine butylbromide may decrease secretions if commenced at the first sign of the symptom. Side effects include increased risk of urinary retention and increased dry mouth so if no reduction in secretions this medication should be stopped
- If secretions are due to an infective cause, anticholinergics are unlikely to be beneficial
- Tracheal suctioning should be avoided at all times
- Yankauer suctioning can be used to remove excessive secretions from a person's mouth

Assessment and management of symptoms *continued*

Agitation, anxiety and restlessness
- Assess for and treat reversible causes of physical discomfort, eg, pain, full bladder, pressure areas, constipation etc, psychological discomfort, spiritual stress, family/whānau concerns and environment
- Consider any recent medication changes that could be the cause of the symptom, eg, dose increases or withdrawal
- Medication that may be required, eg, haloperidol (see medication algorithms)
- There is a difference between hallucinations and death-bed visions:
  - Death-bed visions, eg, the dying person may be seeing someone who is no longer alive; the dying person will appear to be peaceful
  - Hallucinations can be distressing to the person, seeing something they do not like; may benefit from medication intervention

Key care principles

Family support
- Make provisions for family/whānau to remain if they wish
- Offer cultural, spiritual, psychological support to family/whānau
- Offer family/whānau the opportunity to be involved in care as they wish

Skin and pressure care
- Keep the skin clean
- Avoid products that dry or harm the skin
- Pre-care analgesia given prior to repositioning as indicated
- Manage wounds (www.hospice.org.nz/palliative-care-lecture-series/listen-to-lectures)
- Pressure-relieving equipment and regular repositioning
- Use individual's preferred position as often as possible

Health care
- Assess mouth and continue mouth cares – minimum of 4-hourly
- Decide what mouth swab needs to be used (sponge may be too harsh)
- Offer the family/whānau the opportunity to be involved as they wish
- Avoid alcohol-based agents for mouth cares
- Mouth care may be done with the fluid as per the person's wishes
- Consider use of nutritional fluid, eg, miso soup, for cultural consideration

Key care principles *continued*

Eye care
- Eye care should be done minimum of 4-hourly
- Keep eyes clean and moist
- Use eye drops/lubrication as prescribed

Urine output
- Assess bladder for urine retention if person appears agitated
- Keep person dry and comfortable
- Use of incontinent products may be required

Bowel cares
- Optimal bowel care prior to last days of life contribute to overall comfort
- Ensure person is not distressed or agitated by constipation or diarrhoea
- During the dying phase when the person is no longer able to take medication orally, bowel management agents are usually not needed unless the person appears agitated/restless
- If the person becomes agitated/restless, assess and exclude full rectum. Use of suppositories may still be appropriate

⚠ Consider further non-pharmacological symptom control and cultural request as appropriate and as per the person's request, eg, aromatherapy, appropriate music