NHS
Greater Glasgow and Clyde

CLINICAL GUIDELINE

Guidance At End Of Life (GAEL) for Health Care Professionals

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

Version Number:	5
Does this version include changes to clinical advice:	No
Date Approved:	20th December 2023
Date of Next Review:	28th February 2027
Lead Author:	Claire O'Neill
Approval Group:	Medicines Utilisation Subcommittee of ADTC

Important Note:

The online version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

Guidance At End of Life (GAEL) for Health Care Professionals

This guideline is an aid to clinical decision making and good practice. For use when there is irreversible deterioration and the clinical judgement of the multidisciplinary team is that the patient is dying and the Senior Clinician agrees with this. A copy can be printed and put at the front of the patient notes/care plan.

Key Actions When Someone is Dying

An individualised person centred management plan should be agreed and communicated to the patient, relatives and carers. If the patient does not have capacity the plan should be discussed with the Welfare Power of Attorney or Guardian.

This plan should be reviewed daily. Update and communicate any changes with the patient, relatives and carers at least once a day. Documentation should include evidence of:

- Open, honest, sensitive communication addressing any worries or concerns highlighted by the patient, relatives and carers. **Talking about dying**
- Provision of written information if desired. **What Can Happen When Someone Is Dying**
- DNACPR discussion and presence of a signed form in patient notes/care plan. DNACPR decision should be recorded on KIS/Clinical Portal ACP.
- Discussion around what is important to the patient including preferred place of care and death. If home is the preferred place of care refer to **Discharge Guidance for Patients with Palliative Care Needs** and complete a **Community Kardex**
- Discussion if appropriate about tissue/organ donation. **NHSGGC Policy for Organ and Tissue Donation**
- Discussion about plan for fluids and nutrition including the importance of mouth care. **NICE guideline: Care of Dying Adults in the Last Days of Life**
- Ongoing **assessment and management of symptoms** including potential **Palliative Emergencies**
- Prescribed anticipatory/Just In Case (JIC) medications for common symptoms at end of life (see box below).
- Rationalisation/discontinuation of unnecessary medical, nursing and drug interventions.
- **Confirmation of Death** paperwork in relevant settings.

Review, update and communicate any changes with patient, relatives and carers at least once a day.

If specialist Palliative Care advice/referral is required contact Hospital Palliative Care Team or Local Hospices

Anticipatory/Just In Case (JIC) Medication

Scottish Palliative Care Guidelines Anticipatory Prescribing

Pain/Breathlessness	• **Morphine Sulphate injection 2mg SC** repeated at hourly intervals as needed, If 3 or more doses are required within 4 hours with little or no benefit **seek urgent advice or review*.** If more than 6 doses are required in 24 hours **seek advice or review***. • If known moderate/severe renal impairment **Alfentanil** is the opioid of choice. **Renal Disease in Last Days of Life Guideline**
Nausea/Vomiting	• **Levomepromazine 2.5mg to 5mg SC** 12 hourly as needed.
Anxiety/Distress	• **Midazolam injection 2mg SC** repeated at hourly intervals as needed. If 3 or more doses are required within 4 hours with little or no benefit **seek urgent advice or review***. If more than 6 doses are required in 24 hours, **seek advice or review*.**
Respiratory Tract Secretions	• **Hyoscine Butylbromide injection 20mg SC** repeated at hourly intervals as needed. If more than 6 doses are required in 24 hours, **seek advice or review*.**

Key Actions at Time of and After Death

- **Confirmation of Death (CoD) paperwork** is completed in relevant settings.
- Follow Final Act of Care Policy (previously known as Last Offices).
- Support and comfort relatives and carers and offer **mementos/keepsakes** if desired.
- Sensitively return patient belongings using a bereavement bag (hospital setting).
- Sensitively discuss documentation and the written information booklet provided. **When Someone Has Died**
- Explain Medical Certification of Cause of Death (**MCCD**) procedure.
- Community actions – arrange for equipment uplift, provide information to relatives and carers regarding disposal of any drugs (community settings).

***Advice or review can be sought from ward medical staff, pharmacist or Specialist Palliative Care Team**

Significant Discussion about a Patient's Care including Diagnosing Dying are made on the basis of MDT decision

- Support patient to take fluids and nutrition as long as they are able and want to. **NHSGGC Food, Fluid & Nutritional Care Homepage**
- If subcutaneous fluids are indicated discuss and document benefits and burdens. **National Guideline: Subcutaneous Fluids** and **NHSGGC Subcutaneous Fluids: Standard Operating Procedure**
- Consider the need for a subcutaneous infusion of medication via a T34/BodyGuard T syringe pump. **Syringe Pump Guidelines**
- Discuss with patient, relatives and carers their preferences in relation to pressure area care, personal care – specifically oral, bowel and bladder care.
- Ensure all significant conversations are clearly documented.

Each Individual Patient's Physical, Psychological, Social and Spiritual needs are addressed

- It is essential to review the effect of any 'as required' medicine. This will help to direct a review of the overall treatment plan.
- Where possible and in advance identify and document any spiritual, religious, cultural needs or wishes before and after death. **NES Multi-Faith Resource for Healthcare Staff**
- Offer Chaplaincy or preferred faith/community leader if desired.
- Revisit **"What Matters To You?"**
- Ask the patient, relatives and carers about any social or financial concerns that may need to be addressed. **Funeral Costs/Repatriation** and **Money Worries**

Informative, Timely and Sensitive Communication is an Essential Part of each Individual Patient's Care

- Identify if patient already has an anticipatory care plan/advanced directive, living will or desire for organ/tissue donation and revisit sensitively.
- Patient, relatives and carers are kept up to date, regularly asked what is important to them and if they have any worries or concerns.
- Identify any communication barriers and request support. **Interpreting Service**
- Discuss sensitively with relatives and carers if Procurator Fiscal involvement is required.
- Where relevant update KIS/Clinical Portal ACP.

Consideration is given to wellbeing of Relatives and Carers attending the Patient

- Keep relatives and carers updated especially as patient deteriorates.
- Ask relatives and carers how we can support them. **Carers Support**
- Provide information about visiting, car parking and catering (hospital setting).
- If relatives and carers are identified to be at risk of complicated grief, with permission refer to relevant General Practitioner/ Health Care Professional.

NHSGGC Guidance at End of Life for Health Care Professionals is relevant for all settings. For additional support and information on End of Life Care please visit the **Scottish Palliative Care Guidelines**.