ELDERLY MEDICINE

PALLIATIVE CARE IN EM

When all reversible causes for the patient's deterioration have been considered, the multidisciplinary team agrees the patient is dying and changes the goals of care.

Management of a dying patient and their family

Plan and document care.

- **Discuss prognosis** (patient is dying), goals of care (maintaining comfort) and preferred place of care- realistically AMU side room from ED.
- Clarify resuscitation status; **check DNACPR form has been completed**.
- **Reassure the patient and family that full supportive care will continue.**
- **Discontinue inappropriate interventions** (blood tests, IV fluids and medication, vital signs monitoring, frequent blood sugar tests).

Hydration

- Discontinue tube feeding / fluids if respiratory secretions present, if there is a risk of aspiration due to reduced conscious level or at the patient's request.
- Over-hydration contributes to distressing respiratory secretions. Artificial fluids are usually not appropriate, but if indicated can be given subcutaneously.

Symptom control- Anticipatory prescribing

In all patients the following should be prescribed in the 'when required' section of the kardex:

- Opioid analgesic SC, hourly – dose depends on patient, clinical problem and previous opioid use. Prescribe 1/6th of 24 hour dose of any regular opioid or if not on a regular opioid prescribe, **Morphine SC 2mg hourly**.
- Anxiolytic sedative – **Midazolam SC 2–5mg hourly**.
- Anti-secretory medication – **Hyoscine butylbromide (Buscopan®) SC 20mg hourly**.
- Antiemetic – **Levomepromazine SC 2.5–5mg 8–12 hourly or Haloperidol SC 1mg 12 hourly or 2mg once daily.**
- Or if patient's nausea already controlled with an oral antiemetic, then use the same antiemetic subcutaneously.

Management of symptoms

Pain

- **Non-opioid analgesics:** Paracetamol or diclofenac (liquid / dispersible / rectal preparations). **NSAID benefits may outweigh risks** in a dying patient; can help bone, joint, pressure sore, inflammatory pain.
- **Opioid analgesics:** Convert any regular oral morphine or oxycodone to a 24 hours SC infusion – see Opioid conversion flowchart and/or seek advice. Continue fentanyl patches in dying patient. For breakthrough pain, prescribe dose hourly as required by:
  - Calculating 1/6th of the 24 hour of any regular oral or SC opioid.
  - If not on regular opioid, prescribe **morphine SC 2mg.**

Agitation / delirium

- Anxiety / distress – **Midazolam SC 2–5mg hourly as required.**
- Confusion / delirium – **Haloperidol SC 2mg once daily.** There is an **ongoing supply issue** with haloperidol injection. Before prescribing it seek advice from the Palliative Care team.
- Established terminal delirium / distress (**note**: lower doses as suggested above and on page 322 should be tried before progressing to the following higher dose)
  - First-line: **Midazolam SC 20–30mg over 24 hours in a syringe pump + midazolam SC 5mg hourly as required**

Nausea / Vomiting

If already controlled with an oral antiemetic, use the same drug as a SC infusion. Treat new nausea / vomiting with a long-acting antiemetic given by SC injection or give a suitable antiemetic as a SC infusion in a syringe pump. Long-acting antiemetics include:

- **Haloperidol SC 1mg 12 hourly or 2mg once daily.**
- **Levomepromazine SC 2.5mg 12 hourly or 5mg once daily.**

Respiratory tract secretions

Avoid fluid overload; assess fluid balance, stop IV/SC fluids and tube feeding. Changing patient's position may help. Intermittent SC injections often work well or medications can be given as SC infusions. Hyoscine butylbromide is first-line as it is a less sedating alternative to hyoscine hydrobromide.

Hyoscine butylbromide SC bolus 20mg hourly as required (max 120mg/day) *or* **SC infusion 60–120mg over 24 hours**