

CLINICAL GUIDELINES FOR END OF LIFE CARE MEDICATIONS IN LONG TERM CARE HOMES

OPENING STATEMENT: *Insert Facility Name* is committed to providing effective end-of-life symptom management to all residents. Symptom management at end-of-life is the responsibility of each member of the health care team working in collaboration with the resident and their family. The client's self-report is the primary source for information about symptoms. Family or care provider reports are included for those unable to give self-report.

Common end-of-life medications will be stocked in the emergency boxes to manage residents' symptoms.

Facility/LTC home supports the use of the **Clinical Guidelines for End-of-Life Care Medications** to manage the symptoms associated with end of life clinical situations (see appendix 1).

Inclusion Criteria:

All residents designated by a Physician/NP as end of life OR residents whose conditions have changed and are suffering symptoms suggestive of end-of-life.

STANDARDS:

1. Residents' symptoms will be managed in a timely fashion at end of life, following clinical guidelines based on best practice.

PROCEDURES:

1. All PSW's and registered staff will identify end-of-life symptoms (see appendix 2) and report them to a registered staff member (or supervisor). Registered staff will then assess (see appendix 3 & 4) symptoms.
2. Notify appropriate physician of resident's change in status and development of end of life symptoms. Obtain resident specific orders.
3. Implement orders, assess and document effectiveness.
4. Allow pharmacy to stock the medications ordered during normal business hours. Use the medication in the Emergency box only if the pharmacy is closed or there is too long a wait for the medications (eg. the resident is highly distressed).

CLINICAL GUIDELINES:

See Appendix 1

RECORD:

1. Reason for the call and orders received from the Physician.
2. Nursing assessment and resident response in multidisciplinary notes as required.
3. Document medications as required on the MAR.

DEVELOPED IN CONSULTATION WITH:

- Waterloo Wellington Dufferin Hospice Palliative Care Network (WWHPN)
- Project team for the End-of-life Care Medications in Long term Care Homes Project

REFERENCES:

Alberta Hospice Palliative Care Resource Manual by Eduardo Bruera et al 2001 p. 51

Dr. Giovanna Sirianni, Princess Margaret Hospital, UHN Pain conference, 2007 Canadian Family Physician Volume 53, September 2007

Oxford Textbook of Medicine 2005, Page 491, 711, 749, 985

Palliative Medicine Handbook, On-line edition, 2004 By Ian N Back, A,FRCP,MRCGP

99 Questions (and more) about Hospice Palliative Care, Capital Health, Alberta 2006

APPENDIX 1: GUIDELINES

Waterloo Wellington Hospice Palliative Care Network End-Of-Life Care Medications in LTC Homes Clinical Guidelines

This list of medications is not all inclusive. It reflects best practice and the minimum number of medications to stock to minimize suffering of residents at end of life in LTC Homes.

Notify the Physician if any of these symptoms develop. Obtain specific orders for each patient.

Symptom/Availability	Medication	Side Effects	Reference
Terminal secretions <i>Scopolamine (hyoscine hydrobromide) 0.4 mg/ml</i> <u>OR</u> <i>Atropine 1% eye drops</i>	Scopolamine 0.4 mg (1ml) sc q4h prn OR Atropine 1% eye drops – 2 gtts sublingually q3h prn Periodic mouth care should be done for comfort. If secretions are in the airways and patient is too weak to clear them, try repositioning the patient on their side, with their head slightly lowered for positional drainage.	Dry mouth, drowsiness. May cause sedation or agitation in persons who are still conscious. If not responsive in 2-3 doses, will likely not respond.	Oxford Textbook of Medicine 2005 Pg. 985
Seizures <i>Midazolam 5mg/ml</i>	Midazolam 2.5mg (0.5ml)* sc stat and q30 min prn Keep calming environment for patient and family. Transfer to hospital if ineffective.	Long half-life in elderly (days) causing prolonged sedation. *reduced dose for elderly.	Palliative Medicine Handbook, On-line edition, 2004 By Ian N Back, MA,FRCP,MRCGP
Pain <i>Morphine 15mg/ml</i> <u>OR</u> <i>Hydromorphone 2 mg/ml</i>	Notify physician of current pain status and use of analgesics in past 24 hours, to obtain further orders. Note: sc dose = ½ the oral dose Fentanyl 25 mcg/hr = morphine 3-7.5mg (0.2-0.5ml) sc q4h. Fentanyl patches should not be started at end of life. If already in use, do not increase patch, use sc opiate for breakthrough pain. Hydromorphone is 5 times stronger than morphine.	Nausea & vomiting, constipation, sedation, confusion, hallucinations, myoclonus.	Dr. Giovanna Sirianni, Princess Margaret Hospital, UHN Pain conference, 2007 Canadian Family Physician Volume 53, September 2007
End Stage Delirium/ Agitation <i>Midazolam 5mg/ml</i>	<u>Identify possible cause:</u> rectal impaction, urinary retention, increase in pain, medications (opioids, corticosteroids), metabolic derangements (diabetes, hypercalcemia), dehydration, hypoxia and brain metastases. <u>Treat the cause if appropriate.</u> Midazolam 0.5 -5 mg* (0.1-1ml) sc q2h prn See below under Adjuvant medication.	Midazolam is short acting and may require frequent injections. Not covered by ODB. *reduced dose for elderly.	Oxford Textbook of Medicine Pg. 711
Nausea <i>Haloperidol 5mg/ml</i>	Haloperidol 0.5 -1.0 mg (0.1-0.2 ml) sc q4h prn See below under Adjuvant medication.	Restlessness common at higher doses.	Oxford Pg. 491
Severe Dyspnea <i>Morphine 15mg/ml</i> <u>OR</u> <i>Hydromorphone 2mg/ml</i>	Recommended Treatment for Dyspnea If patient is on opioids, increase breakthrough dose by 30% to treat dyspnea. Starting doses for the opiate naïve patient may be: Morphine 3-5 mg (0.2-0.33 ml) sc q1h prn Hydromorphone 0.5 – 1.0 mg (0.25-0.5ml) sc q1h prn Open window, fan blowing air, quiet calm atmosphere. Consider oxygen therapy at low flow rate.	As above for opioids for pain.	Alberta Hospice Palliative Care Resource Manual by Eduardo Bruera et al 2001 Pg. 51
Anxiety/Distress <i>Lorazepam 4mg/ml</i>	Lorazepam 0.5-1mg (0.125-0.25ml) sc q4h prn	Can cause increased agitation in elderly.	Oxford text Pg. 749
Adjuvant medication <i>Nozinan (methotrimeprazine) 25mg/ml</i>	Nozinan may be useful for: 1. poorly controlled nausea & vomiting nausea: Nozinan 2.5 - 5mg (0.1-0.2ml) sc q6h 2. <u>end stage delirium</u> to clear sensorium delirium: Nozinan 5-25* mg (0.2-1ml) sc bid-tid prn	Sedation. *reduced dose for elderly	99 Questions (and more) about Hospice Palliative Care, Capital Health, Alberta 2006

APPENDIX 2 **PHYSICAL SIGNS OF APPROACHING DEATH**

Adapted from: When someone is dying brochure, Hospice Palliative Consultation Services of Wellington Dufferin

Please note: This list is not all inclusive.

Food and Fluid

Loss of appetite and decrease in thirst are common. The body is beginning to shut down and does not need nourishment. People commonly feel it is necessary to encourage the person to eat in the hope of sustaining life; however, food and fluid may cause discomfort. The person may ask for ice chips, popsicle's, ice cream or some other food of choice. Do not be surprised if only a mouthful or two is taken. When swallowing is no longer possible, mouth care provides moisture and comfort. Do not give fluids if unable to swallow.

Elimination

Urine output and bowel function will decrease as the food and fluid intake decrease. Urine and stool may also change colour, be passed less frequently and in smaller amounts. Other factors such as immobility and medication may contribute to this.

The person may lose control of bladder or bowel function as the muscles begin to relax. In this instance it may be necessary to use an incontinence brief.

Using incontinence briefs will help until you can talk to a health care professional about the management of these symptoms.

It is important to provide skin care and cleansing on a routine basis. Nursing services may be available to help you.

Sleeping

Sleeping an increased amount of time is common. It may become more difficult to waken the person. As death nears, the person may slip into a coma and become unresponsive.

Restlessness and Distortion

Confusion as to time, place and recognition of people is common. This can include members of the family and close friends. At times the person may become restless. For example: she/he may reach out to unseen objects, pull at bedclothes, or try to get out of bed. This can occur for many reasons such as a decrease in oxygen circulation to the brain, changes in their condition or medications. It would be helpful to discuss these changes with a health care professional.

Breathing

Regular breathing patterns may change. Breathing may become noisy due to mucous collecting in the throat, and because of the relaxation of the throat musculature. You may notice more labored or shallow breathing (there may be periods of no breathing). These breathing patterns are normal and indicate the natural progression towards death.

Congestion

Gurgling sounds, often loud, occur when a person is unable to cough up normal secretions. This does not normally cause any pain or discomfort. It may be helpful to turn the person to one side and gently wipe away secretions with a moist cloth. As secretions build up, keeping the head of the bed elevated (pillows can be used), will make breathing easier. Sometimes a medication can be ordered to help dry up secretions.

Skin

You may notice the skin begin to change colour and be cooler to touch. The underside of the body may become purplish and mottled. Hands and feet may feel cool to touch. The circulation of blood is slowing down. Although the person is cool to touch, he/she is usually comfortable.

APPENDIX 3 EDMONTON SYMPTOM ASSESSMENT SCALE

**Edmonton Symptom Assessment System (ESAS)
Numerical Scale**

Please circle the number that best describes:

No pain 0 1 2 3 4 5 6 7 8 9 10

Worst possible pain

Not tired 0 1 2 3 4 5 6 7 8 9 10

Worst possible tiredness

Not nauseated 0 1 2 3 4 5 6 7 8 9 10

Worst possible nausea

Not depressed 0 1 2 3 4 5 6 7 8 9 10

Worst possible depression

Not anxious 0 1 2 3 4 5 6 7 8 9 10

Worst possible anxiety

Not drowsy 0 1 2 3 4 5 6 7 8 9 10

Worst possible drowsiness

Best appetite 0 1 2 3 4 5 6 7 8 9 10

Worst possible appetite

Best feeling of Wellbeing 0 1 2 3 4 5 6 7 8 9 10

Worst possible feeling of wellbeing

No shortness of Breath 0 1 2 3 4 5 6 7 8 9 10

Worst possible shortness of breath

Other Problem 0 1 2 3 4 5 6 7 8 9 10

Worst possible _____

Patients Name _____

Date: _____ Time: _____

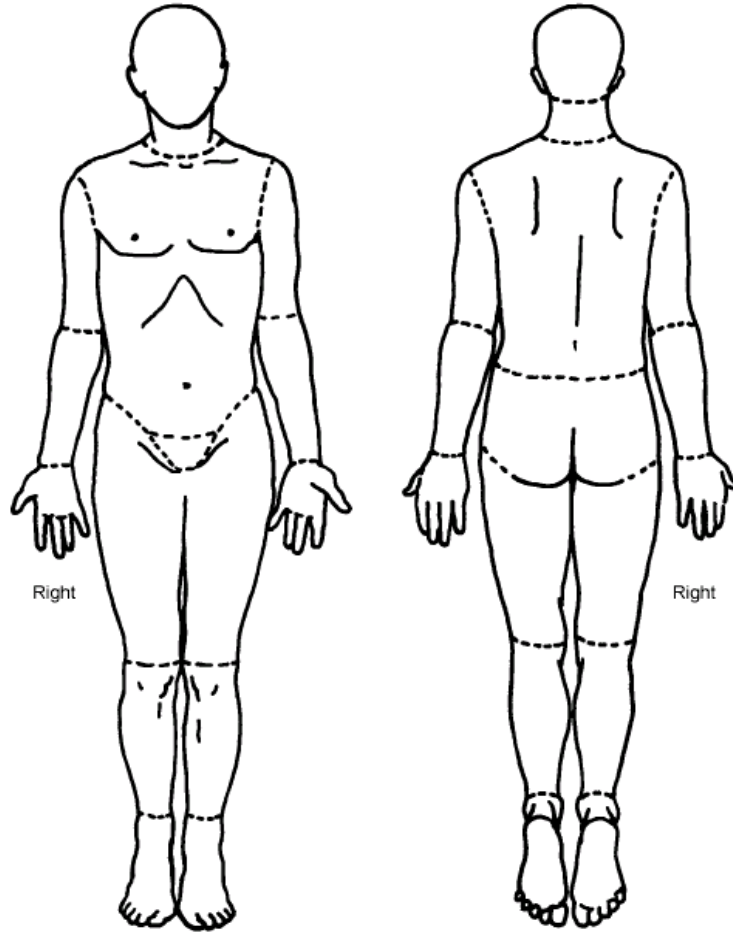
Completed By: (check one)

- Patient
- Caregiver
- Caregiver assisted

APPENDIX 3 cont. EDMONTON SYMPTOM ASSESSMENT SCALE

Body Diagram

Please mark on these pictures where it is you hurt:





Palliative Performance Scale (PPSv2)
version 2

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity <i>with</i> Effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-

Instructions for Use of PPS (see also definition of terms)

1. PPS scores are determined by reading horizontally at each level to find a 'best fit' for the patient which is then assigned as the PPS% score.
2. Begin at the left column and read downwards until the appropriate ambulation level is reached, then read across to the next column and downwards again until the activity/evidence of disease is located. These steps are repeated until all five columns are covered before assigning the actual PPS for that patient. In this way, 'leftward' columns (columns to the left of any specific column) are 'stronger' determinants and generally take precedence over others.

Example 1: A patient who spends the majority of the day sitting or lying down due to fatigue from advanced disease and requires considerable assistance to walk even for short distances but who is otherwise fully conscious level with good intake would be scored at PPS 50%.

Example 2: A patient who has become paralyzed and quadriplegic requiring total care would be PPS 30%. Although this patient may be placed in a wheelchair (and perhaps seem initially to be at 50%), the score is 30% because he or she would be otherwise totally bed bound due to the disease or complication if it were not for caregivers providing total care including lift/transfer. The patient may have normal intake and full conscious level.

Example 3: However, if the patient in example 2 was paraplegic and bed bound but still able to do some self-care such as feed themselves, then the PPS would be higher at 40 or 50% since he or she is not 'total care.'

3. PPS scores are in 10% increments only. Sometimes, there are several columns easily placed at one level but one or two which seem better at a higher or lower level. One then needs to make a 'best fit' decision. Choosing a 'half-fit' value of PPS 45%, for example, is not correct. The combination of clinical judgment and 'leftward precedence' is used to determine whether 40% or 50% is the more accurate score for that patient.
4. PPS may be used for several purposes. First, it is an excellent communication tool for quickly describing a patient's current functional level. Second, it may have value in criteria for workload assessment or other measurements and comparisons. Finally, it appears to have prognostic value.