

FLOWCHARTS

Dignified Death

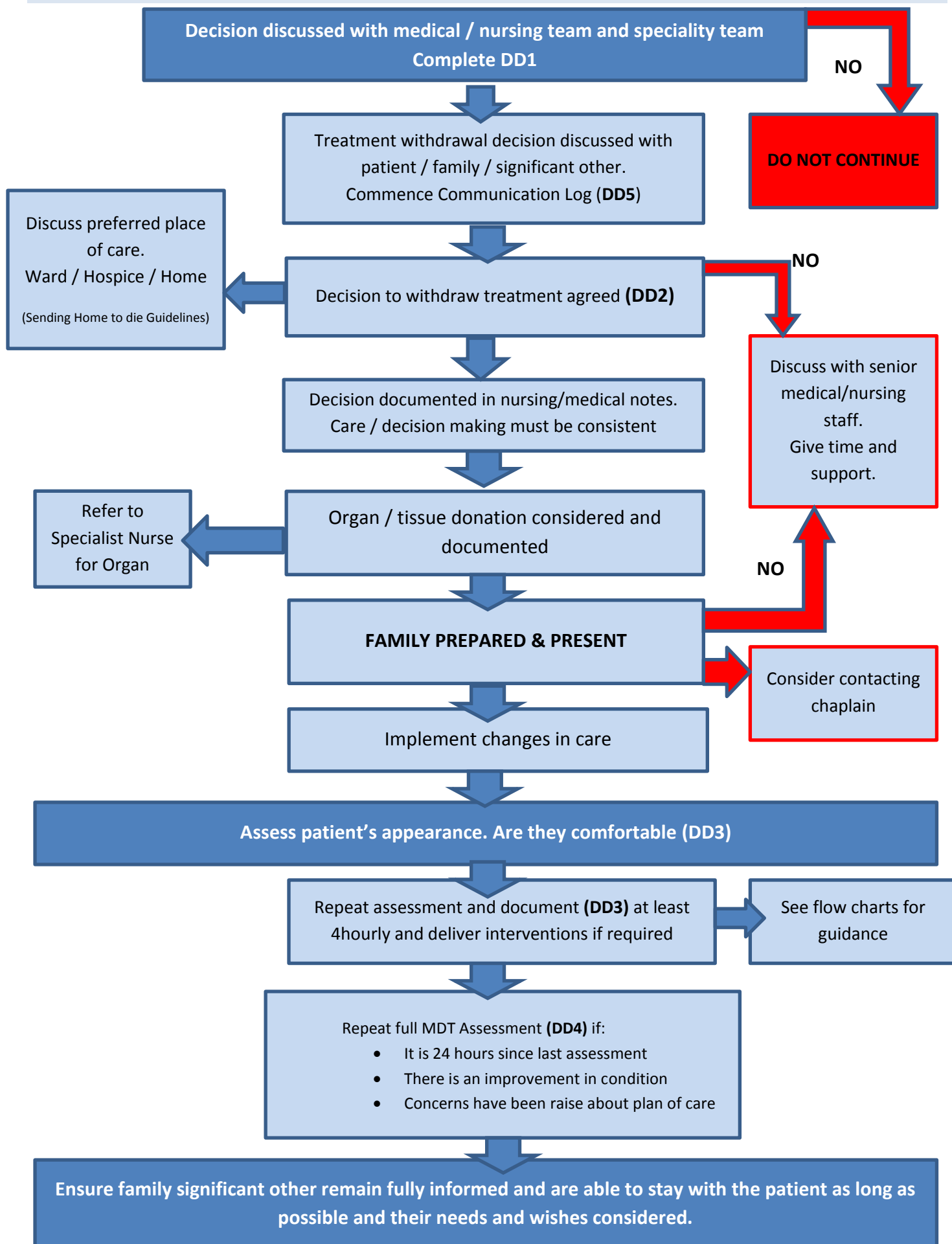
Guidance for End of Life Care
In Critical Care Units



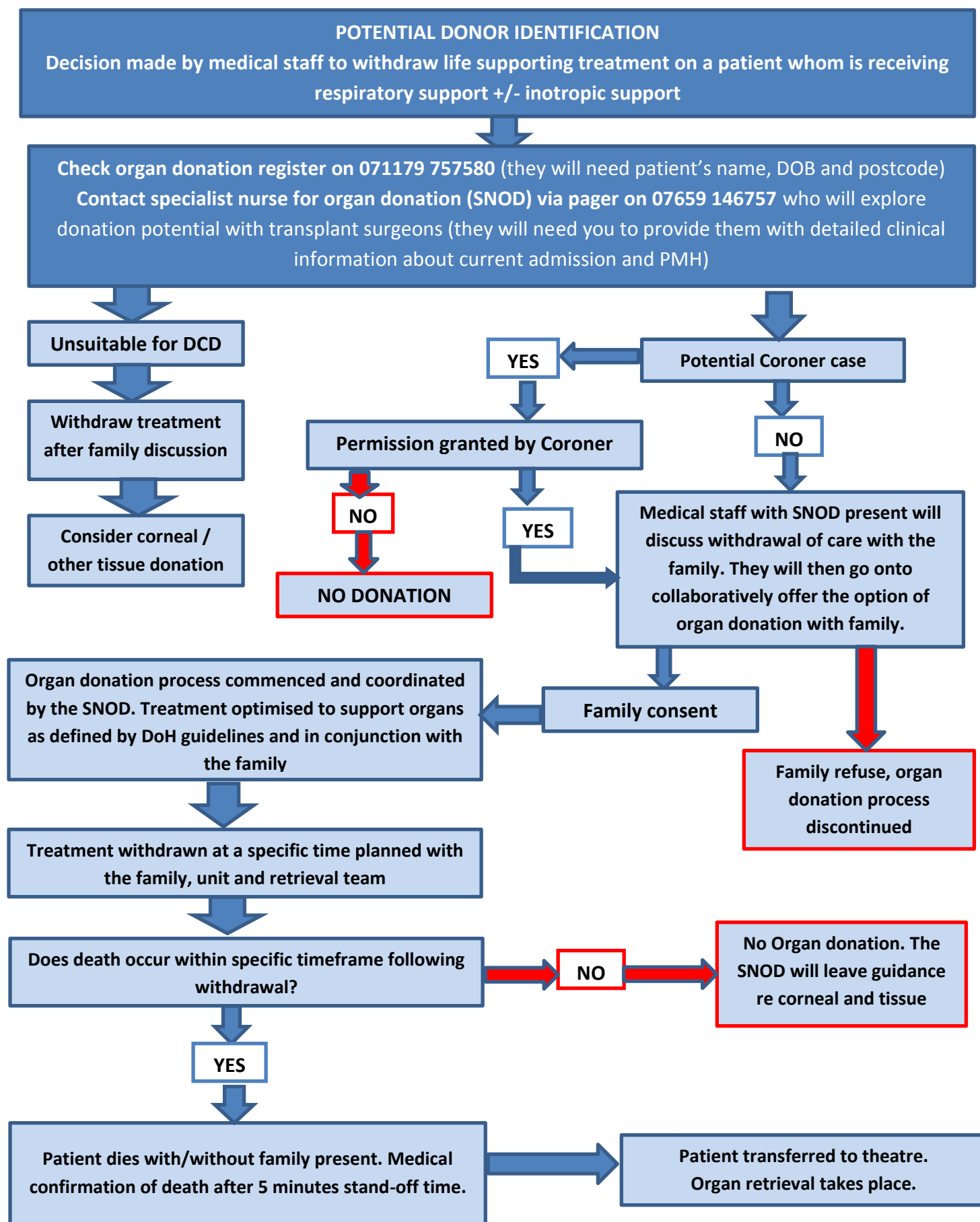
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WITHDRAWAL OF TREATMENT – ALGORITHM



Organ donation After Circulatory Death (DCD)



REFERRAL OF POTENTIAL CORNEAL / TISSUE DONORS

PATIENT DECEASED**Is the patient a potential tissue donor?**

Corneas	3-90 years
Heart valves	32 weeks gestation – 65 years
Bone	>17 years
Tendons	18 – 60 years
Meniscus	18-45 years
Arteries	17-60 years
Skin	No age limit but >57kgs

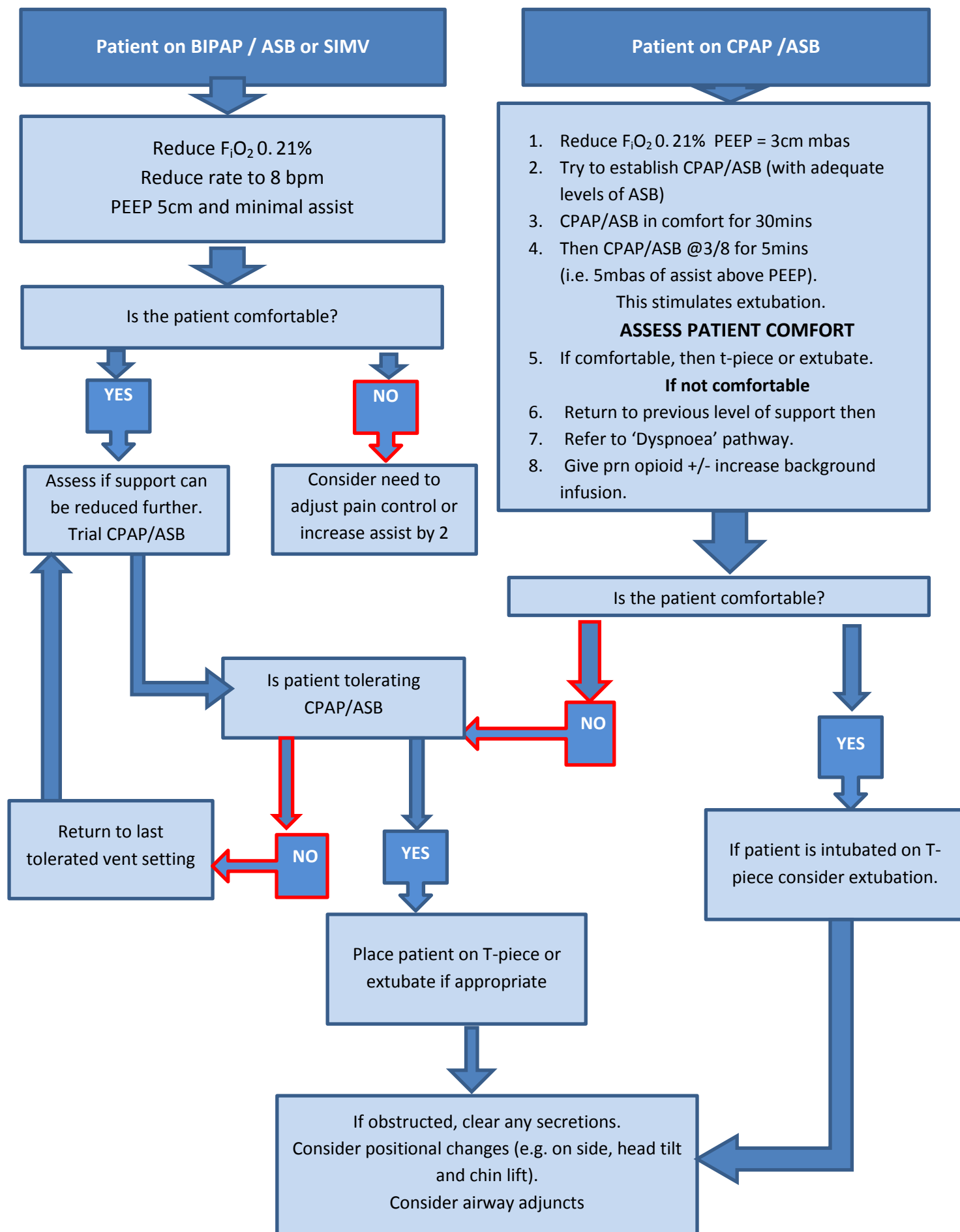
Contra - indications

Known HIV, hepatitis B or C or in high risk group
Sexual partners of the above
CNS disorders e.g. Parkinsons, Alzheimers, ME
Acute viral infection
Confirmed rabies
Malaria, parasitic disease, TB, congenital rubella, Reyes syndrome
Previous transplant surgery

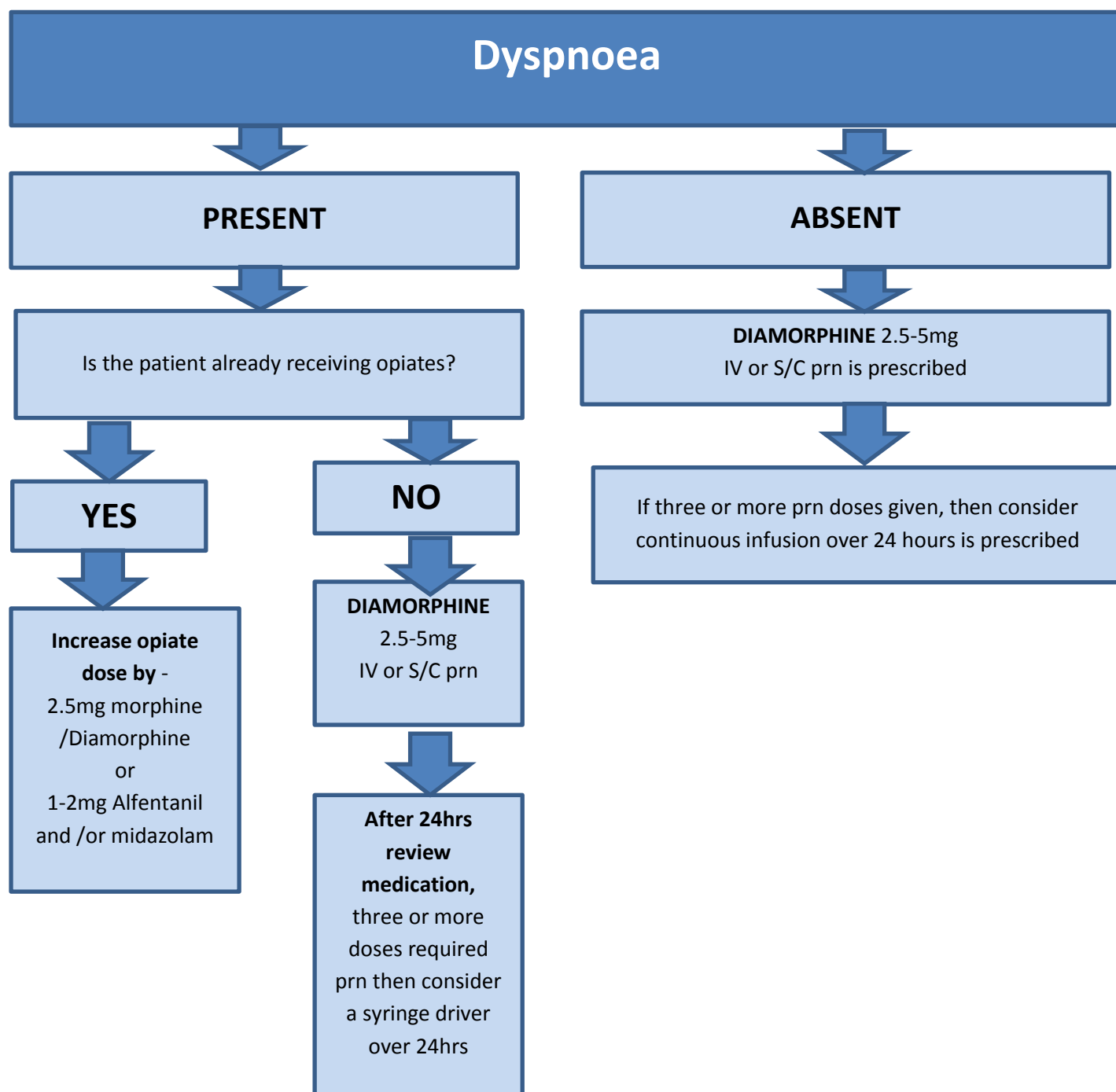
IF ANY OF THESE ARE PRESENT DO NOT APPROACH THE FAMILY**Is the patient on the ORGAN DONATION REGISTER? (ODR)****Ring 01779 757580 (they will ask for name, DOB and postcode)****NB: Not being on the ODR does not preclude donation, families can still be approached to ask about deceased's previously expressed wishes regarding tissue donation.****Medical or nursing staff approach the family about the option of tissue donation****Permission given from the family to be contacted via telephone by tissue services to take telephone consent.****Ring tissue services co-ordinator 0800 4320559****Provide patient details as per tissue proforma****Tissues co-ordinator will liaise with the coroner if required****Tissue services co-ordinator will ring family at home, take consent over the phone and organise retrieval****Give family with tissue donation leaflet****Patient must be in mortuary within 6 hours. Inform mortuary that patient is going to be a tissue donor**

GUIDELINES FOR REDUCTION OF VENTILATORY SUPPORT IN CRITICAL CARE

Ensure effective communication during reduction process with patient and family / significant others. Assess the patient for signs of distress and treat accordingly.



**GUIDELINES FOR CONTROL OF DYSPNOEA
VIA IV OR S/C ROUTE IN CRITICAL CARE**

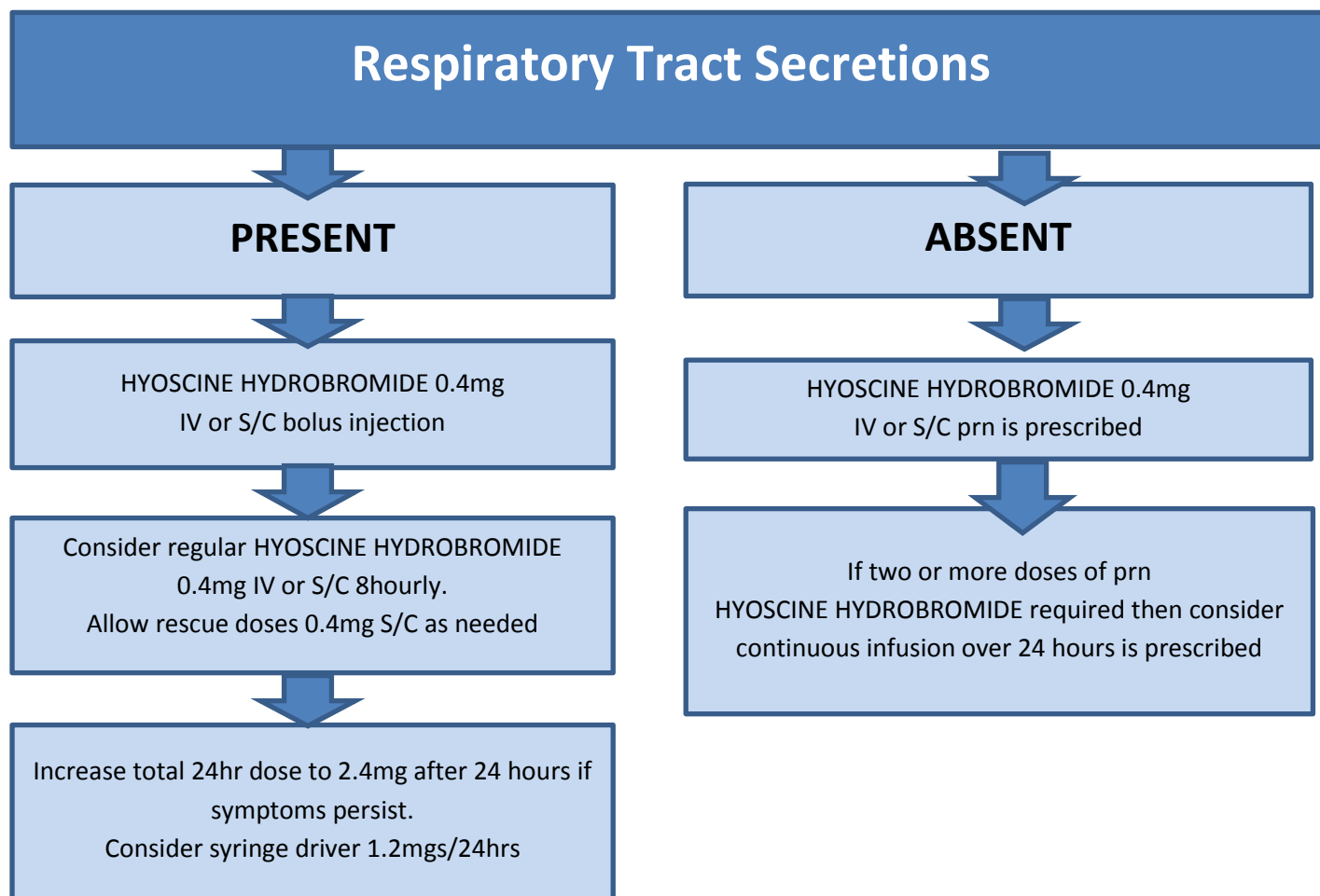


Supportive Information:

- If the patient is breathless and anxious already on opiates consider Midazolam stat 2.5mg IV or S/C prn, or an infusion of Midazolam 20mgs over 24hours IV or S/C.
- If symptoms persist contact the Palliative Care Team for advice.
- **Anticipatory prescribing in this manner will ensure that in the last few hours / days of life there is no delay responding to symptom control if it occurs.**

THESE GUIDELINES MAY BE ALTERD FOR LOCAL USE.

**GUIDELINES FOR CONTROL OF EXCESSIVE RESPIRATORY SECRETIONS
VIA IV OR S/C ROUTE IN CRITICAL CARE**

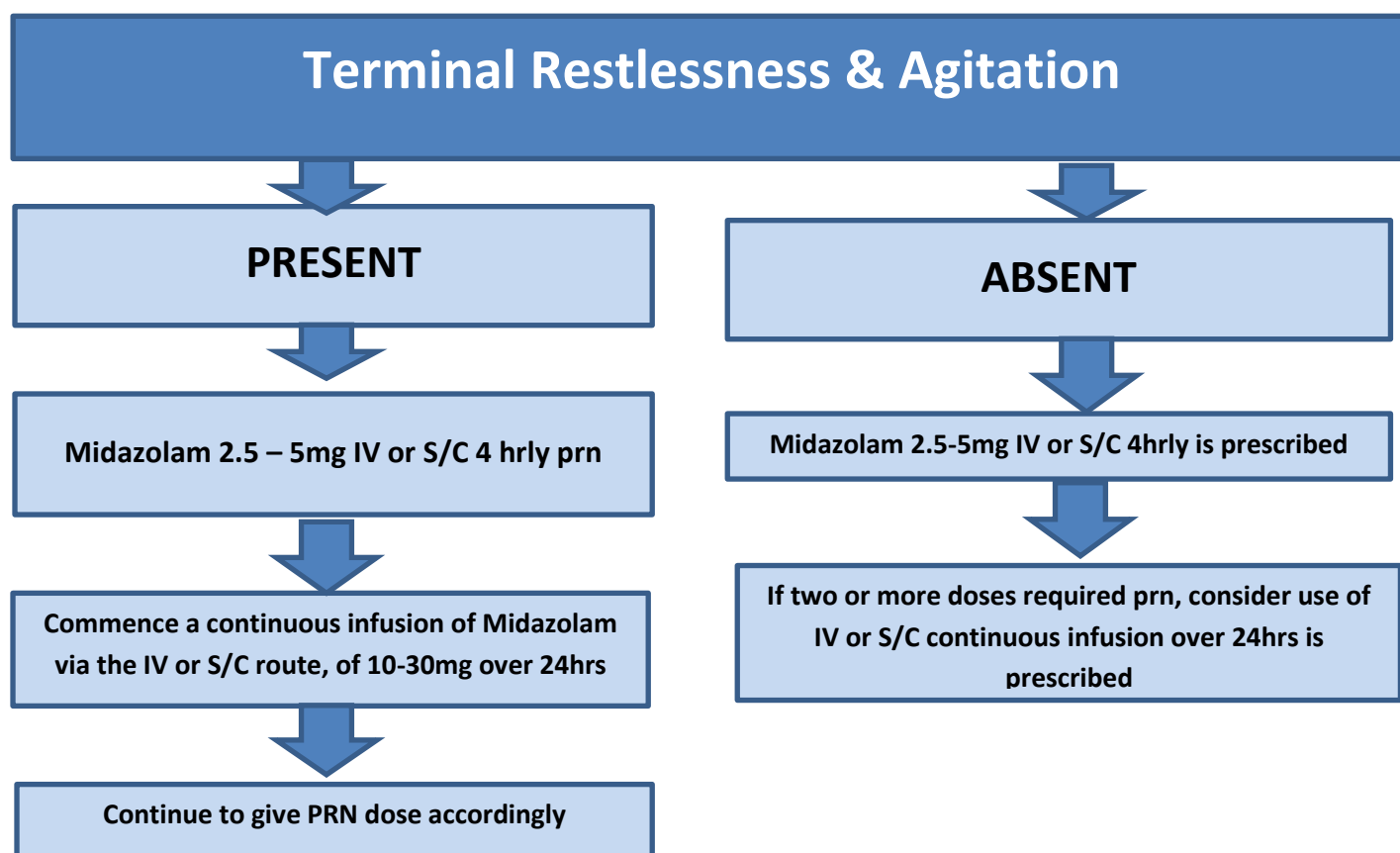


Supportive Information:

- If symptoms persist contact the Palliative Care Team for advise
- Use of appropriate medication may reduce the need for suction
- Glycopyrolate 0.4mg IV or S/C prn may be used as an alternative
- **Anticipatory prescribing in this manner will ensure that in the last hours /days of life there is no delay responding to a symptom if it occurs.**

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**GUIDELINES FOR CONTROL OF TERMINAL RESTLESSNESS & AGITATION
VIA IV OR S/C ROUTE IN CRITICAL CARE**

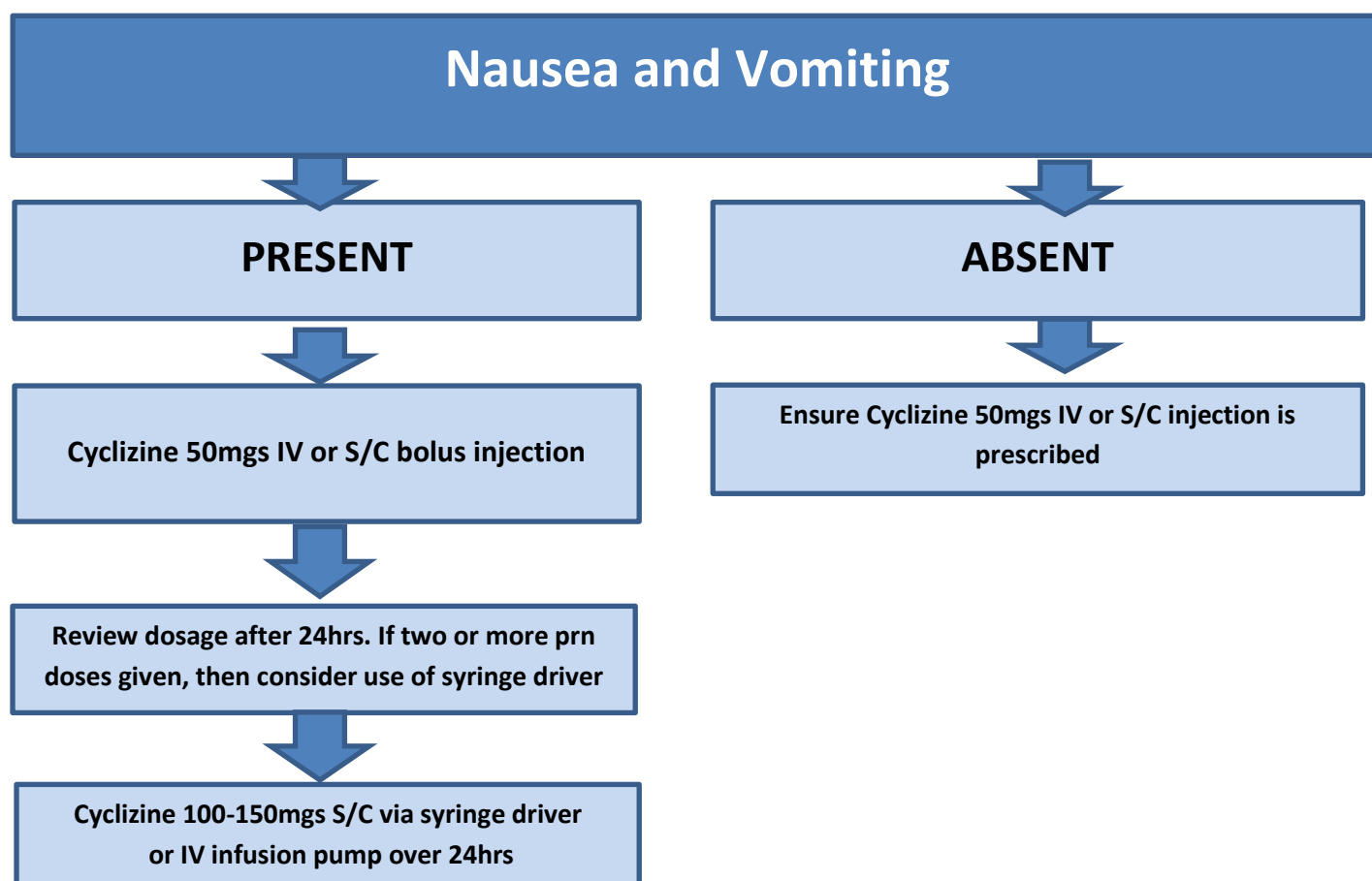


Supportive Information:

- Midazolam is presumed to be equipotent when given IV or S/C
- Consider levomepromazine
- If symptoms persist contact the Palliative Care Team
- Anticipatory prescribing in this manner will ensure that in the last hours/days of life there is no delay in responding to a symptom if it occurs.

THESE GUIDELINES MAY BE ALTERD FOR LOCAL USE.

**GUIDELINES FOR CONTROL OF NAUSEA AND VOMITING
VIA IV OR S/C ROUTE IN CRITICAL CARE**



Supportive Information:

- Always use water for injection when making up Cyclizine
 - If symptoms persist contact the Palliative Care Team
 - Cyclizine is not recommended in patients with heart failure
- Alternative anti-emetics according to local policy & procedure may be prescribed
Ondansetron and dexamethasone maybe useful within the first 5 days postoperatively
- **Anticipatory prescribing in this manner will ensure that in the last hours/days of life there is no delay in responding to a symptom if it occurs.**

THESE GUIDELINES MAY BE ALTERD FOR LOCAL USE.

GUIDELINES FOR END OF LIFE PAIN CONTROL IN PATIENTS ON CRITICAL CARE

THESE GUIDELINES MAY BE ALTERD FOR LOCAL USE.

Does the patient have IV access

YES

Is the patient on an IV opiate infusion?
i.e. standard regime of morphine 1mg / 1ml or
Alfentanil in 0.9% saline via an infusion pump

YES

IS THE PATIENT IN PAIN?

YES

**Give prn bolus of opioid
within prescribed range.**

1mg Alfentanil,
2-5mg Morphine IV
or 1-2 mg Diamorphine

**Increase IV baseline infusion
rate of opioid by 2-5mg per
hour as needed**

NO

IS THE PATIENT IN PAIN?

NO

**Ensure PRN dose of
Morphine 2-5mgs IV
is prescribed of
Diamorphine**

YES

**Give PRN dose of
Morphine 2-5mgs IV or 1-
2.5mgs Diamorphine**

**Commence IV infusion
1 mg/ml morphine via a
syringe driver 5-10
mg/hr or 2.5-5mg**

Continue IV opioid

**Ensure appropriate range
or bolus dose is
prescribed.**

1mg Alfentanil,
2-5mg Morphine IV

NO

S/C access

Continuous S/C Diamorphine

If the patient has been on IV morphine divide
total dose by 2 and give this dose of
diamorphine S/C over 24hrs via a syringe driver.

PRN S/C Diamorphine

To calculate the prn dose of diamorphine divide the
24hr dose of Diamorphine by 6.
E.g. if the patient is receiving 60mg of Diamorphine
S/C over 24hrs the required PRN dose is 10mg.

**If the patient is not in pain ensure prn dose
of diamorphine 2.5 – 5mgs S/C is**

Supportive Information:

- To convert from strong opioids contact Palliative Care Team /pharmacy for further advice and support as required
- If symptoms persist contact the Palliative Care Team
- Morphine 5 -10mg S/C prn may be utilised as an alternative
- Anticipatory prescribing in a manner will ensure that in the last hours/days of life there is no delay responding to a symptom if it occur.

