ICU Care of the Dying Patient Plan

This document guides medical and nursing management after a consensus decision is made to cease life-prolonging therapies and actively transition to comfort cares only, as well as, support family and significant others. See the Bereavement folder for more information on accessing support resources.

	✓/NA
1. Patient and Family	
Patient/family/'person responsible' in consensus for cessation of life-prolonging therapies, including review of advanced care plan if available	
Religious/spiritual/cultural needs considered, Pastoral Care brochure provided and (intranet) referral flowchart followed if required.	
Social worker/bereavement team notified or referral sent	
Bereavement information provided to family/significant others	
Patient/family meeting documented in medical records	
2. Resuscitation status	
MR 85 completed	
3. Organ donation	
DonateLife and Lions Eye Donation Service contacted for potential organ/cornea donation	
If applicable, Nurse Donation Specialist contacted to arrange a Family Donation Conversation (FDC) specialist to enquire into patient/family wishes regarding donation	
Organ donation process commenced	
4. Comfort measures	
Medication prescribed for symptom control** e.g. to relieve pain, anxiety or dyspnoea	
Pressure cares attended with consideration of pressure relieving devices	
Bedside monitor display off (central monitor can be used to follow patient progress)	
5. Therapies/monitoring to be discontinued	
Extubate/NIV/oxygen therapy ceased	
Inotropes and vasopressors	
IV fluids	
Enteral feeding/ TPN	
CRRT	
Medications (other than for comfort care) ceased on drug chart	
Documenting vital signs	
AICD deactivated, Cardiology team notified?	
Removal of unnecessary vascular access devices	
6. Environment	
Unnecessary medical equipment removed from the patient cubicle e.g. ventilator	
Consideration of personalisation/ambience measures* e.g. special blankets/toys, electric candles	
7. Notifications	
Patient likely to survive to transfer to acute or subacute ward/hospice care – Palliative Care referral	
Parent team aware of palliative plan	
General Practitioner aware of palliative plan	
8. Coronial matters	
Coroner notified	
Family notified of coronial referral	
Statement of identification obtained (if family do not wish to stay until police arrival)	

*Please refer to the Bereavement folder for a list of resources and location guide for physical aids to help with spiritual, psychological and existential distress, and assist in creating a soothing atmosphere for the patient.

**Existing dosing requirements must be considered when prescribing, particularly in the ICU setting. Dosing should be regular for persistent distressing symptoms. PRN dosing may be considered for intermittent symptoms. Dose ranges below are suggested starting doses only. (Adapted from eTG complete: Palliative Care; accessed 11/12/2017)

Pain

Morphine is the usual opioid used.

Regular:

Morphine 2.5-5mg regularly q4h, iv or sc, OR, sc infusion – starting at 10-15mg/24h

PRN:

Morphine 2.5-5mg PRN q1h, iv or sc

Alternatives may be considered if:

- Moderate-severe renal impairment
- Severe liver impairment
- Allergy
- An alternative opioid is currently providing effective pain relief

Accumulation of morphine metabolites may lead to distressing adverse effects such as myoclonic jerks.

Additional agents to consider:

Clonazepam 0.5mg twice daily, orally, sc or sl (maximum 2mg bd).

Dexamethasone 4-8mg daily, orally or sc (useful for peritumour oedema and inflammation e.g. raised intracranial pressure, nerve plexus compression, obstruction of hollow viscus, liver capsule distention)

Dyspnoea

Regular:

Morphine 1-2.5mg regularly q4h, iv or sc, OR, sc infusion – starting at 5-10mg/24h

PRN:

Morphine 1-2.5mg PRN q1h, iv or sc

Alternatively, or in addition to opioids:

Regular:

Clonazepam 0.2-0.5mg q12h, sl or sc

OR

Midazolam 10-20mg/24hr sc infusion

PRN:

Clonazepam 0.2-0.5mg q2h PRN, sl or sc

OR

Midazolam 2.5mg q1h PRN, sc or iv

Anxiety (also see agitation and dyspnoea)

Lorazepam 0.5-1mg orally or sl, repeat in 1hr if required

Intractable hiccups

Clonazepam 0.5mg twice daily, orally, sc, or sl

OR

Haloperidol 0.5 – 1mg daily, orally, sc or sl

OR

Metoclopramide 10mg 8 hourly, orally or iv

Multifocal myoclonus

Consider changing opioid if possibly causative.

Clonazepam 0.5mg twice daily, orally, sc, or sl

OR

Midazolam 2.5 – 5mg, sc or iv, OR as continuous sc infusion 5-20mg/24hrs

Respiratory secretions

Glycopyrrolate 200mcg sc q2h (up to 1200mcg/24hrs)

OR

Hysocine butylbromide 20mg sc q2h (up to 120mg/24h)

If there is no improvement after 12-24h, consider stopping. If found to be useful, both agents can be given regularly q4h at the same dose.

Agitation

Clonazapam and midazolam can be used at the same doses as for managing dyspnoea.

Alternatively, or in addition to a benzodiazepine, add haloperidol:

Regular:

0.5-1mg q12h OR 1-2.5mg/24h sc infusion

PRN:

0.5-1mg q4h PRN