

RECOGNISING DYING

Recognising dying can be complex. Many older people living in residential care are frail and have one or more chronic illnesses. The changes will vary from person to person and may affect all major organs of the body, including the brain, heart, lungs, liver and kidneys.

Common signs a person may be in their last days of life

- Rapid day to day deterioration where the residents condition keeps getting worse
- Needing more frequent care
- Moving in and out of consciousness
- Finding it harder to swallow
- · Refusing or unable to eat, drink or take oral medications
- Losing a lot of weight
- Becoming increasingly tired and very weak
- · Breathing becoming more difficult
- Becoming restless, agitated and confused

Multidisciplinary Assessment

If the above signs and symptoms are present a Multidisciplinary team assessment is required. Assessment considerations include;

- Is there a reversible cause? E.g. hypercalcemia, delirium, drug toxicity
- Could the resident be approaching the last days of life
- Is further support needed to assess condition? Is referral to specialist palliative care appropriate?

Communication

The resident (if appropriate), health professionals caring for the resident, and family and whanau communication is focussed on recognising and understanding

- wishes –review the Advance Care Plan if available
- fears and concerns around dying
- preferences and appropriateness of place of death
- level of information required

Plan of Care

The plan of care focuses on individual needs and comfort. A Last days of life care plan is developed in consultation with the resident (if appropriate) and family and whanau.

Regular assessment of all care needs will ensure comfort and dignity. Changes can occur rapidly in the last days of life and anticipatory and prompt response is necessary for residents. The care plan should include after hours planning.







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ALGORITHM

Decision making in recognising dying and use of the care plan to support care in the last hours or days of life.

Deterioration in the person's condition suggests that the patient could be dying. Multidisciplinary Team (MDT) Assessment · Is there a potentially reversible cause for the person's condition? Eg exclude opioid toxicity, renal failure, hypercalcaemia, infection. • Is there an advance decision to refuse treatment, Advance Care Plan, Advanced Directive? · Does the person have the capacity to make their own decisions on their own treatment at this moment in time? • Is the person being cared for in the most appropriate setting or place of their choice? • Is a specialist referral needed? For example Specialist Palliative Care or a second opinion. · Is there an expressed wish for organ/tissue donation? · The support of an advocate as appropriate. CLINICAL DECISION The person is NOT recognised as dying (in the last hours or days of life) The person IS recognised as dying (in the last hours or days of life) Review the current plan of care The person (where appropriate) and relative or carer communication is focused on recognition and understanding that the patient is dying Discussion with the person and relative or carer to explain the new COMMUNICATION or revised plan of care Discussion with the person (where appropriate) and relative or carer to explain the current plan of care The Last Days of Life Care Plan is commenced including initial, then ongoing regular assessments MANAGEMENT A full multidisciplinary team (MDT) reassessment and review of the current plan of care should be triggered when one or more of the following apply: REASSESSMENT Concerns expressed Improved consciousness level, functional ability, regarding management oral intake, mobility, plan from either and/or ability to perform person, relative or carer self-care or team member

Always remember that the Specialist Palliative Care Teams are available for advice and support, especially if:

Symptom control is difficult and/or if there are difficult communication issues or you need advice or support regarding your care delivery supported by the care plan.

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