| **D**ecision-making **and E**nd-of-**L**ife-care **in E**mergency **(DandELinE)** | Work Place Instruction |  |
| --- | --- |

**(Delete this box after reading – for information only)**

***Note:*** Work place instructions are not published and are document controlled locally within the unit they are developed for. They are low risk and allow a level of flexibility. The responsibility for the instruction remains solely with the line manager of that unit/service. Please ensure your review the document and update the grey highlight text to locally contextualise this work place instruction.

**Definition**

# Work Place Instructions (WPI) are documents which offer suggestions on a specific task to be undertaken in a specific location, e.g. the preparation process for opening/closing a clinic or how to use a specific piece of equipment. They are guidelines to best practice which can be related to clinical, managerial, operational and technical activities, within a particular work unit/area or service group.

# Scope

This work place instruction applies to ***<update to local context >***.

# Purpose

This work place instruction outlines the process for Decision-making and End-of-Life care in Emergency departments (ED), (DandELinE). The processes are designed to support ED staff when making decisions regarding care and treatment for patients at or nearing end of life.

# Instruction

Caring for patients requiring a palliative approach in the ED can be difficult and stressful for all involved. Early identification of these patients can lead to more appropriate and timely decisions for treatment and disposition planning.

The process includes:

* Locating previous advance care planning documents/ discussion records;
* Identifying patients who are nearing end of life or imminently dying;
* Determining the appointed Enduring Power of Attorney (EPOA) for health matters or other legal substitute decision maker (SDM);
* Discussing treatment options with the patient or EPOA / SDM;
* Documentation of outcomes and discussion;
* Implementing the [Care Plan for the Dying Person](https://qheps.health.qld.gov.au/__data/assets/pdf_file/0030/385851/sw270.pdf) or the (ieMR) Palliative care management -adult, Terminal Phase, Interdisciplinary Plan of Care (IPOC);
* Medication prescribing guidelines for pain and symptom management;
* Disposition planning.

The DandELinE flowchart is not intended to be followed strictly in order, e.g. discharge planning, may begin with the ***<update to local context>*** *e.g. text - Patient Access Coordination Hub (PACH) team>* prior to the patient arriving in ED.

All members of the interdisciplinary team should consider if the patient could be dying and to verify appropriateness of care at any time during the presentation. All staff are encouraged to engage in or respond to discussions regarding ACP with the patient, carer or substitute decision maker.

All required resources are available in the ***<update to local context*** *e.g. text - DandELinE trolleys located in acute and the Short Stay Unit procedure room>.* It is expected that ED staff will increase their capacity to initiate and provide end-of-life care in the ED by using these resources. ***<update to local context*** *e.g. text - The specialist Palliative Care team will continue to provide consult liaison support, as required>.*

## Locating previous Advance Care Planning (ACP) documentation

The triage process must include determining if the patient has any existing ACP documents (see Appendix 3). These may be filed in the health record or available on The Viewer in the ACP tracker. A history of ACP conversations and activity may also be available in the ACP tracker.

***<Update to local context>*** *e.g. text* Refer to the procedure for Advance care planning – recording discussions and documentation.

Confirm that the documents are the most recent/ up-to-date and valid (signed and dated appropriately) and bring these documents to the attention of the treating medical officer.

## Identifying patients who are imminently dying or at risk of dying in the short term

**Medical officer**

Determine what the patient hopes to achieve during this presentation. Establish their understanding of their health care, elicit goals of care, values and preferences. Confirm with the patient that any existing ACP documents remain current. If not, revoke where necessary and complete new documents.

When assessing the patient, consider:

* Does this patient show signs of advancing disease – unstable, deteriorating, complex symptom burden? Do they have an existing condition/s with a risk of dying from a sudden acute crisis in their condition?
* Is the patient showing signs of frailty or had frequent admissions recently for the same symptoms with little or no improvement?
* Will providing active or life prolonging treatments lead to a meaningful outcome that is in line with the patient wishes and their acceptable quality of life?
* What will be the benefit to the patient in performing diagnostic tests/ procedures?
* Would it be a surprise if the patient died within the next few days/ weeks/ months? How does the patient wish to spend these last days?

Seek consensus opinion and discuss with senior medical officer, as required. Health providers are under no legal or ethical obligation to offer or provide futile medical treatment (treatment that affords no benefit and would cause harm to the patient). Under the law, patients with capacity provide their own consent and may refuse life-sustaining treatment, even if this results in their death or would cause it to happen sooner.

## Determine the appointed Enduring Power of Attorney (EPOA) for health matters or Substitute Decision Maker (SDM)

ACP documents come into effect if the patient no longer has the capacity to speak for themselves, engage in and consider all the available treatment / care options, and make decisions regarding their health care.

The [Queensland guardianship legislation](file:///\\HERSTON-CL1_SC_DATA10\DATA10\ZONAL\Metro%20North\COSI\04%20Care%20at%20the%20End%20of%20Life\Deliverables\SEED\Statewide%20implementation%20project\DandELinE\%3cupdate%20to%20local%20context) provides a consenting priority list for adults with impaired capacity:

1. Advance Health Directive;
2. Tribunal appointed Guardian;
3. Valid EPOA (for health matters);
4. Statutory Health Attorney (over 18yrs old, readily available, willing and culturally appropriate) in the following order:
5. Spouse in close and continuing relationship;
6. Primary unpaid carer;
7. Close adult friend or relative (not paid carer);
8. The Public Guardian.

## Discussing treatment options with the patient or EPOA/ SDM

Decisions and conversations with relatives and carers of patients about resuscitation status, advance care plans and patient wishes can be difficult and should be handled in a sensitive, compassionate and professional manner. The overall treatment plan should be discussed in the context of what can and can’t be done (within reasonable limits of what is achievable) for the patient in a sensitive, yet honest way. This conversation may include discussion, in broad terms, of available treatment options, palliative care and other support measures.

Remember to involve the Social Worker, Aboriginal and Torres Strait Islander Hospital Liaison Officer and Spiritual/ Pastoral care, if required.

If end-of-life care is not the appropriate and agreed decision, cease the DandELinE process and treat as required.

## Documentation of outcomes and discussion

Delicately handled conversations can relieve anxiety and avoid misunderstandings or unrealistic expectations further along the clinical path. Limitations must be clearly spelled out and be consistent with information already communicated. It is imperative to make a clear decision and communicate it to all treating clinicians by providing details of these conversations clearly in the health record. The guardianship law includes a legal requirement to document the decision-making pathway.

***<Update to local context>*** *e.g. text* Refer to the procedure Advance care planning – recording discussions and documentation.

## Implementation of the care plan for the dying person

**Nursing staff**

When the decision has been made to provide end of life care, retrieve the required documentation pack and medication device pack from the DandELinE trolley. Record the UR number/ attach a patient identification label to the Trolley Stock Use Record (Appendix 6) and complete the form as items are used.

**Non-ieMR sites**

The multidisciplinary team (MDT) should use the [Care plan for the dying person](https://qheps.health.qld.gov.au/__data/assets/pdf_file/0030/385851/sw270.pdf), which contains:

* Details of the MDT involved in commencing the care plan;
* Initial assessment;
* Family/ carer information sheet (to be torn out and given to the family/ carer during discussions);
* Ongoing assessment;
* Clinical notes section;
* Care after death.

The care plan supports the delivery of high-quality care tailored to the individual’s needs and forms a comprehensive ‘checklist’ of the essential elements of end of life care. The family / carer information ‘tear-out’ sheet is used to support the information provided in previous discussions with the patient / family during the decision-making process.

The ongoing assessment section presents symptoms in a ‘track and trigger’ format with prompts for management options.

Commencement of this care plan in the ED supports transition of care and facilitates clinical handover if the patient is transferred to another ward / facility.

ieMR sites use the Palliative Care Management Adult, Terminal Phase, Interdisciplinary Plan of Care (IPOC).

***All end-of-life care patients in ED should be commenced on:***

* *Palliative Care Management Adult*
* *Terminal Phase in the Interdisciplinary Plan of Care (IPOC) in ieMR, OR*
* *The Care Plan for the Dying Person*

## Medication prescribing guidelines for pain and symptom management

**Medical officer**

As a person reaching the end of life begins to deteriorate, their regular medications may not need to be administered. Cease any medications that are not required for comfort or symptom management, including IV fluids and in some instances, oxygen therapy.

The important medications to remember charting (particularly before the patient leaves the emergency department) are for pain, anxiety / agitation, increased secretions and nausea/ vomiting.

* Use the DandELinE PRN Medication Guideline (Appendix 4) which details the most frequently required medications to manage symptoms. The preferred route of administration is subcutaneous.
* Consider replacing the patient’s current symptom management medications with a continuous sub-cutaneous infusion (CSCI). The Palliative Care Consult Liaison team offer 24-hour support and assistance if required and are contactable via switchboard.

***REMEMBER: Doses conversion may be required for patients who are currently receiving opioids.***

## Disposition planning/ transfer and accommodation of dying patients

Patient preferences are given priority when determining where best to care for the dying patient. Every effort must be made to quickly accommodate the patient in the most suitable area or preferred location for their end-of-life care. Religious or cultural preferences should be accommodated wherever possible.

End-of-life care must be tailored to the individual needs of the patient and their family/ carers. Consider these needs when determining what information, resources and mementos (e.g. quilt) are provided. Provide bereavement support for families/ carers and staff as required.

### Patient wishes to die at home or usual place of residence

Some patients, and/or their family or carers may wish for the patient to return home to be cared for through the end of life and after death. In most cases, palliative care support will be required for patient, family and carers.

If the patient is **already known** to Palliative Care, contact the Palliative Care nurse (in hours) if the management plan has been altered. After hours, contact ***<Update to local context>*** *e.g. text Dove Palliative Care Unit.*

If the patient is **not known** to Palliative Care, contact the Palliative Care registrar for referral. Discharging these patients after hours should be avoided, if possible.

**Medical officer**

Prescribe medications for symptom management and pain control. Notify the GP, provide a copy of the ARP and complete the “Not for CPR” letter. Appendix 5

**Nursing staff**

If a patient arrives with a Niki pump insitu, ensure the Niki pump is returned with the patient. Provide the family / carer with the DandELinE information pack (available in the DandELinE trolley) including the family / carer section from the Care plan for the dying person; the Surefuser+ booklet (if required) and a copy of ‘The dying’ process.

If not previously provided by the Social Worker, include a copy of the ***<Update to local context>*** *e.g. text ‘*When someone dies booklet’ in the information pack. It may be appropriate to offer the patient a quilt, handcrafted and donated by the Sunshine Linus Inc. Quilters if they have not previously received one from the Adem Crosby Centre.

**Social Worker and Aboriginal and Torres Strait Islander HLO**

Provide resources as required for the individual patient.

**Pharmacist**

If the patient is returning to a Residential Aged Care Facility, ensure the EDMAR and Subcutaneous Medication Infusion Device Chart are completed.

### Patients who wish to die in hospital / Palliative Care Unit

**Medical officer**

Refer patient for admission under the appropriate specialty and prescribe adequate medications for symptom management and pain control. Complete the Interim Management Plan (IMP) if appropriate or if not appropriate, discuss with admitting registrar regarding a rapid review.

**Nursing staff**

Contact the ***<Update to local context>*** *e.g. text* PACH team to arrange/ confirm fast track admission to the relevant ward or facility. Commence any prescribed continuous subcutaneous medications and provide care as per the Care plan for the dying person.

**NOTE**: Patients who are to be transferred from ***<Update to local context>*** *e.g. text* SCUH to another facility require:

* A Surefuser+ ™ for continuous sub-cutaneous medications;
* A copy of the ARP and the “Not for CPR” letter (Appendix 5).

NOTE: It may be necessary to use the ***<Update to local context>*** *e.g. text Transit* Unit (if appropriate) for patients who are waiting Inter-hospital transfer or transport home. The non-urgent non-ambulance (NUNA) vehicle may also be a suitable option for transferring patients to Palliative Care Unit or a local Residential Aged Care Facility (RACF). Patients requiring transport are to be provided with a copy of the ARP and “Not for CPR” letter (Appendix 5).

### Patients who are imminently dying

**Medical officer**

Complete the Short Stay management plan (LINK) and prescribe medications for symptom management and pain control.

**Nursing staff**

Transfer to room 15 in the Short Stay Unit, ***<Update to local context>*** *e.g. text* or Single Room bed 4 at NGH as soon as possible. Continue as per the (ieMR) Palliative Care Management Adult, Terminal Phase in the Interdisciplinary Plan of Care (IPOC).

***<Update to local context>*** *e.g. text See* local procedure Care and management of deceased patients (adult and paediatric) and the supporting checklist.

# References and further reading

Primary legislation, policy, standards or other authority

Guardianship and Administration Act 2000

Queensland Powers of Attorney Act 1998

Clinical Excellence Division: End of life care: Guidelines for decision-making about withholding and withdrawing life-sustaining measures <https://www.health.qld.gov.au/__data/assets/pdf_file/0033/688263/acp-guidance.pdf>

National consensus statement: essential elements for safe and high-quality end-of-life care <https://www.safetyandquality.gov.au/wp-content/uploads/2015/05/National-Consensus-Statement-Essential-Elements-forsafe-high-quality-end-of-life-care.pdf>

<https://www.safetyandquality.gov.au/wp-content/uploads/2017/12/National-Safety-and-Quality-Health-Service-Standards-second-edition.pdf>

Statewide strategy for end-of-life care May 2015 <https://www.health.qld.gov.au/__data/assets/pdf_file/0022/441616/end-of-life-strategy-full.pdf>

Clinical Excellence Division: Advance Care Planning Clinical Guidelines January 2018 <https://www.health.qld.gov.au/__data/assets/pdf_file/0037/688618/acp-guidelines.pdf>

National Safety and Quality Health Service Standards 2nd ed – Comprehensive care

Other supporting documents

Advance health directive website and forms: <https://www.qld.gov.au/law/legal-mediation-and-justice-of-the-peace/power-of-attorney-and-making-decisions-for-others/advance-health-directive/>

Acute resuscitation plan form <https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/patient-safety/end-of-life/resuscitation/overview>

Statement of choices (SoC) form A: For persons with decision-making capacity, and form B: For persons without decision-making capacity

Enduring power of attorney: <https://www.qld.gov.au/law/legal-mediation-and-justice-of-the-peace/power-of-attorney-and-making-decisions-for-others/power-of-attorney/>

SCHHS Practice Development, Advance Care Planning: Introducing a Conversation Tool ID 000031

End-of-life Essentials: Education Modules, End of Life Directions for Aged Care <https://www.eldac.com.au/>

# Consultation

* Palliative Care team, Emergency Department clinicians, Director Pharmacy
* Compliance
* Palliative Care Management Adult, Terminal Phase, Interdisciplinary Plan of Care, (patients dying in the ED)
* IHT of dying patients with Care Plan for the Dying Person commenced in ED
* 90% of end-of-life care patients in the ED will be managed as per this pathway.

Will providing active treatment or life sustaining measures:

* Align with the Substitute Decision Maker (SDM) or patient wishes?
* Lead to a meaningful outcome for this patient?
* Be consistent with ‘good medical practice’?

Seek consensus opinion and discuss with senior medical officer

Treat condition as required MO - Discuss and record future management options and ARP with patient / SDM

Consider the reversibility of this condition

Deterioration in patient’s condition indicates the patient could be dying

No

Yes

1. Discuss options and overall treatment plan with patient / SDM
2. Consensus agreement that the person is likely to be dying
3. Clinical decision to provide palliative approach to care
4. Document in health record
5. If required contact social worker *<Ph No. X>* or A&TSI HLO *<Ph No. X>*

*Under the law patient with capacity may refuse life-sustaining treatment, even if this results in their death or would cause it to happen sooner.*

| Appendix 1: DandELinE Pathway For ieMR sitesDecision-making and End-of-Life-care in Emergency: DandELinE |  |
| --- | --- |

**Commence the Care Plan for the Dying Person**

* Min 2hrly symptom assessment and comfort observation
* Follow the Care Plan for the Dying Person Ongoing Assessment form

**Treating Medical Officer**

* Complete / review ARP
* Contact Consult Palliative Care team as needed
* Review Medications
  + Stop those not required for comfort (including IV fluids)
  + Aim for subcutaneous administration route
  + Chart end-of-life PRN meds

**Dignity and comfort are the priority**

Does the patient prefer to die at home?

**Discharge**

Contact:

* Pall Care – *<Ph No. X>* or switch A/H re: - Advice re meds (Reg/Consultant A/H) - Arrange community follow-up (Nurse)
* Pharmacy - *<Ph No. X>* in hrs., consider - ‘Scripts for subcut infusion & PRNs - EDMAR or IMAR (if Nursing Home patient) - Subcut Medication Infusion Device Chart for Nursing Home patient
* GP – for follow-up / notification
* Provide required pain / symptom relief
* Provide Information Pack inc. copy of the ARP and “Not for CPR” letter

**Admit**

* Contact PACH - *<Ph No. X>* to confirm / arrange fast track admission to relevant ward/facility
* Refer for admission under appropriate specialist
* Complete IMP and R/V end-of-life PRN meds
* Subcut Medication Infusion Device Chart for inpatient
* Cont. Care Plan for the Dying Person and Ongoing Ax form

**Immediate transfer to single room - SSU Rm 15**

* Continue as per Care Plan for the Dying Person and Ongoing Ax form
* Provide adequate pain and symptom relief – consider subcut infusion
* Transit Unit – *<Ph No. X>* as an alternative if required / appropriate
* Complete Deceased Body Checklist as per local procedure - *Deceased patient care and management: adult and paediatric patients*

Transit unit may be appropriate

Transport – *<Ph No. X>* may be available for *<X>* transfers or *<X>* to *<X>*

Utilise the Surefuser™+ for transfers to other facilities

Ensure bereavement support for the family / carer

Support / debrief with staff as necessary

Resources available in DandELinE trolley

Complete required documentation for deceased patients – see DandELinE trolley

Is the patient imminently dying?

Yes

No

No

Yes

**Commence the Care Plan for the Dying Person**

* Minim 2 hourly symptom assessment and comfort observation
* Follow the Care Plan for the Dying Person Ongoing Assessment form

**Treating Medical Officer**

* Complete / review ARP
* Contact Consult Palliative Care team as needed
* Review Medications
  + Stop those not required for comfort (including IV fluids)
  + Aim for subcutaneous administration route
  + Chart end-of-life PRN meds

**Dignity and comfort are the priority**

Does the patient prefer to die at home?

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Contact:

* Pall Care – *<Ph No. X>* or switch A/H re: - Advice re meds (Reg/Consultant A/H) - Arrange community follow-up (Nurse)
* Pharmacy - *<Ph No. X>* in hrs., consider - ‘Scripts for subcut infusion & PRNs - EDMAR or IMAR (if Nursing Home patient) - Subcut Medication Infusion Device Chart for Nursing Home patient
* GP – for follow-up / notification
* Provide required pain / symptom relief
* Provide Information Pack including copy of the ARP and “Not for CPR” letter

**Admit**

* Contact PACH - *<Ph No. X>* to confirm / arrange fast track admission to relevant ward/facility
* Refer for admission under appropriate specialist
* Complete IMP and R/V end-of-life PRN meds
* Subcut Medication Infusion Device Chart for inpatient
* Cont. Care Plan for the Dying Person and Ongoing Ax form

**Immediate transfer to single room - SSU Rm 15**

* Continue as per Care Plan for the Dying Person and Ongoing Ax form
* Provide adequate pain and symptom relief – consider subcut infusion
* Transit Unit – *<Ph No. X>* as an alternative if required / appropriate
* Complete Deceased Body Checklist as per local procedure - *Deceased patient care and management: adult and paediatric patients*

Transit unit may be appropriate

Transport – *<Ph No. X>* may be available for *<X>* transfers or *<X>* to *<X>*

Utilise the Surefuser™+ for transfers to other facilities

Ensure bereavement support for the family / carer

Support / debrief with staff as necessary

Resources available in DandELinE trolley

Complete required documentation for deceased patients – see DandELinE trolley

Is the patient imminently dying?

Yes

No

No

Yes

| Appendix 2: DandELinE Pathway for non ieMR sitesDecision-making and End-of-Life-care in Emergency: DandELinE Will providing active treatment or life sustaining measures:   * Align with the Substitute Decision Maker (SDM) or patient wishes? * Lead to a meaningful outcome for this patient? * Be consistent with ‘good medical practice’?   Seek consensus opinion and discuss with senior medical officer  Treat condition as required MO - Discuss and record future management options and ARP with patient / SDM  Consider the reversibility of this condition  Deterioration in patient’s condition indicates the patient could be dying  No  Yes   1. Discuss options and overall treatment plan with patient / SDM 2. Consensus agreement that the person is likely to be dying 3. Clinical decision to provide palliative approach to care 4. Document in health record 5. If required contact social worker *<Ph No. X>* or ATSI HLO *<Ph No. X>*   *Under the law patient with capacity may refuse life-sustaining treatment, even if this results in their death or would cause it to happen sooner.* |  |
| --- | --- |

## 

#### Appendix 3: ACP Documents

# Advance Care Planning Documents

## Acute Resuscitation Plan (ARP)

An Acute Resuscitation Plan (ARP) are used in all Queensland Health facilities and are a clinician’s record of discussions with a patient or their substitute decision maker (SDM) about resuscitation planning if there is an acute event, e.g. cardiac or respiratory arrest.

It is not a legal document, nor does it substitute for legal consent. It is a clinician’s record and provides clinical authority to act when urgent decisions are required. An ARP can be valid for the current admission, until a specified future date, or subsequent admissions.

An ARP form should be reviewed from time to time, depending on recommendations from by the medical officer who completed the form or changes to the patient's clinical or personal circumstances.

When a new ARP form has been initiated the superseded ARP form must be voided.

If a patient is transferred to another facility, the original ARP form must remain in their medical record at the original facility. The discharging medical officer may determine that it is appropriate for a copy of the patient's ARP form to accompany them and other medical records to the facility to which they are being transferred.

The receiving facility/ treating team should consider the information on the copy of the ARP form and if appropriate, the treating medical officer should complete a new ARP form for use at that facility.

## Advance Health Directive (AHD)

An AHD is a legal document that formally records a patient’s instructions for future health care for a time when they may be unable to communicate their wishes.

AHDs come into effect only if the patient has lost capacity to make their own decisions.

## Enduring Power of Attorney (EPOA)

An EPOA is a legal document that enables a person to appoint another person or persons to make personal, health and/ or financial decisions on their behalf if they lose capacity to make their own decisions, e.g. if failing cognitive health.

Attorneys may be nominated to make decisions either independently or jointly.

## Statement of Choices (SoC)

SoC form A to be completed by persons with decision-making capacity, or SoC form B to be completed for persons without decision-making capacity.

The SoC is an advance care planning tool that focuses on a patient’s values, wishes and beliefs. It can help a patient’s substitute decision maker to make healthcare decisions, if a patient is unable to make decisions for themselves. The SoC is not a legal document but a record of a patient’s preferences for health care. The information contained in this document can be used to guide management of care. Appropriate discussion of treatment or care options and consent for medical treatment still needs to be sought from the patient or their substitute decision maker. These discussions must then be documented in the health record.

The SoC can be completed by patients and/ or their families independently, or discussed and completed jointly with medical, allied health or nursing staff.

#### Appendix 4: DandELinE - PRN Medication Guidelines

# DandELinE - PRN Medication Guidelines

**Chart ONE PRN medication for EACH symptom**

**Anticipatory prescribing is recommended for all symptoms**

**Check ADR / Allergy for all medication options listed below**

|  |  |  |  |
| --- | --- | --- | --- |
| **Symptom** | **First Choice** | **Second Choice** | |
| **PAIN / DYSPNOEA**  **NOTE: *If patient pain remains poorly controlled after 2 hrs. or requires more than 3 - 4 prn doses within 6 hrs.:***   * ***Contact Palliative Care for assistance with prescribing a continuous sub-cutaneous infusion*** * ***Continue hourly pain monitoring*** * ***Continue prn therapy*** | **Morphine**  Dose: **2.5 mg – 5 mg subcutaneous inj**  Frequency**: Every 30 minutes prn**  *Contra-indication:* Renal failure | **Fentanyl**  Dose: **25 MICROg – 50 MICROg subcutaneous inj**  Frequency: **Every 30 minutes prn** | |
| **These doses are recommended for the opioid naïve patient – seek assistance as required for conversion of baseline medications. Call switch (9) for Palliative Care Consultant if required** | | |
| **AGITATION**  **RESTLESSNESS**  **ANXIETY**  **(including ‘air hunger’)** | **Midazolam**  Dose: **2.5 mg - 5mg subcutaneous inj**  Frequency**: 1 (one) hourly prn**  Max. dose/24hrs: **20 mg / 24 hours** | **Haloperidol**  Dose: **0.5 mg – 1 mg subcutaneous inj**  Frequency**: 3 hourly prn**  Max. dose/24hrs: **5 mg / 24 hours**  *Contra-indication:* Parkinson’s, Dystonic reaction | |
| **NAUSEA**  **&**  **VOMITING** | **Haloperidol**  Dose: **0.5 mg – 1 mg subcutaneous inj**  Frequency**: 3 hourly prn**  Max. dose/24hrs: **5 mg / 24 hours**  *Contra-indication:* Parkinson’s, Dystonic reaction | **Ondansetron**  Dose: **4 mg Sublingual**  **(or intravenous if required)**  Frequency**: 8 hourly prn**  Max. dose/24hrs: **24 mg / 24 hours**  *Contra-indication:* Constipation | **Metoclopramide**  Dose: **10 mg subcut inj**  Frequency**: 4 hourly prn**  Max. dose/24hrs: **40 mg / 24 hrs**  *Contra-indication:* Dystonic reaction, bowel obstruction, Parkinson’s |
| **SECRETIONS**  **(RESPIRATORY TRACT)** | **Hyoscine Butylbromide (Buscopan)**  Dose: **10 mg - 20 mg subcutaneous inj**  Frequency**: 2 hourly prn**  Max. dose/24hrs: **120 mg / 24 hrs** | **Glycopyrrolate**  Dose: **200 MICROg - 400 MICROg subcutaneous inj**  Frequency**: 2 hourly prn**  Max. dose/24hrs: **1200 MICROg / 24 hrs.** | |

**Consider replacing the patient’s usual symptom management medications with a subcutaneous infusion**

**If uncertain about anticipatory prescribing for your dying patient or pain/symptoms remain poorly controlled after 1-2hrs, contact Palliative Care via switch.**

#### Appendix 5: Not for cardio-pulmonary resuscitation letter

Draft text for a not for cardio-pulmonary resuscitation letter below. A template is provided at [www.health.qld.gov.au/careatendoflife](http://www.health.qld.gov.au/careatendoflife).

Date

*<Affix Patient ID label>*

**Cardio-pulmonary resuscitation (CPR) is not appropriate.**

This patient is in the advanced stage of an incurable disease.

During the recent inpatient admission, the matter of CPR has been fully discussed with this patient and/or next of kin and proxy decision maker. The patient and/or next of kin or proxy decision maker has decided that in the event of a cardio/respiratory arrest they **DO NOT WISH** to have CPR.

Should this patient die en route, please proceed to the hospital of destination or RACF or the patient’s home.

We have advised relatives / carers not to call an ambulance if the patient gradually loses consciousness or is found unconscious or unresponsive as part of the normal dying process.

In such circumstances, the relative/carer should instead contact the General Practitioner and/or the Community Nurse.

Dr *<Full name>*

*<Position>*

*<Signature>*

#### Appendix 6: DandELinE trolley stock use record

# Trolley stock use record | Decision-making and End-of-Life-care in Emergency: DandELinE

Place a tick in the column when stock is used for end-of-life care patients in Emergency Department.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Attached ID label / provide UR number** | **Date** | **Niki pump pack used** | **Surefuser+ pack used** | **Info pack envelope given** | **“When someone dies/ booklet provide** | **Quilt given** | **Memory box given** | **End of life care bag used** |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |

## Supporting documents

|  |  |  |
| --- | --- | --- |
| **Type** | **Title** | **Document ID** |
| Primary protocol/procedure/guideline | * *<Insert>* | *<Insert>* |
| Associated forms and templates | * *<Insert>* | *<Insert>* |
| Related documents and references | * *<Insert>* | *<Insert>* |

## Risk Rating

|  |  |
| --- | --- |
| **Level of risk** | **Low**  *All local instructions should be of low risk*  *Risk Matrix check here:* [*http://qheps.health.qld.gov.au/cairns/docs/risk-matrix-chhhs.pdf*](http://qheps.health.qld.gov.au/cairns/docs/risk-matrix-chhhs.pdf) |

## Communication and Implementation Plan

|  |  |
| --- | --- |
| **Action** | **Responsible Position** |
| List communication, education and training available to support implementation:   * *<Insert Action>* |  |

## Instruction Approval

|  |  |  |
| --- | --- | --- |
| **Approval Date: / /** | **Effective Date: / /** | **Review Date: / /** |
| **Approving Officer:** | <Insert name and title> | **Signature:** |
| **Supersedes:** | *<This is the name and number of any document/s that this document replaces (including previous versions of the same document).>* | |
| **Aligned to:** |  | |

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