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GDL17
Care in the Last Days of Life Guideline for Adult Patients (aged 18 years and above)

1.0 Procedure Statement

The importance of good end of life care, both for the patient and their loved ones, is increasingly recognised. Caring for people who are dying is the responsibility of all health care professionals and we have a duty to provide the same quality of care as all other patients (1). We must ensure we treat patients and their loved ones in the last days of life with dignity, respect, and compassion (2).

This guidance has been produced to help address some of the issues that may arise when caring for a patient who is thought to be in the last hours to days of their life.

It should be used as a reference guide to support the completion of the SWAN '**Care in the Last Days of Life Individual Plan of Care**' document.

The Palliative Care Team are available 7 days a week for advice and support via extension 85212 from 08:00-17:00. In adhering to this Policy, all applicable aspects of the Conflicts of Interest Policy must be considered and addressed. In the case of any inconsistency, the Conflict-of-Interest Policy is to be considered the primary and overriding Policy.

2.0 Accountabilities

The Palliative Medicine Directorate is the owner of this policy.

Professional leads and managers of medical, nursing, and allied healthcare professionals are accountable for distributing this guideline to all relevant staff within their spheres of responsibility

3.0 Guideline Detail

3.1 The SWAN Individualised Plan of Care:

Once it has been recognised that someone is in the last days of life, it is important to use the **SWAN Individual Plan of Care** to allow that person to be cared for in a way that is tailored to their personal needs. SWAN (Signs, Words, Action, Needs) is a national model used to support clinicians in giving individualised and person-centred end-of-life and bereavement care (3).

The document is based on the **Five Priorities for Care of the Dying Person** (1) and is a simple, concise way of communicating important

information about the individual and allows hospital staff to know how to best support the patient and their loved ones during this time.

3.2 The Five Priorities of Care:

When it is thought that a person may die within the next few days or hours the key priorities are:

1. This possibility is recognised and communicated clearly, decisions made, and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed, and decisions revised accordingly.

2. Sensitive communication takes place between staff and the dying person, and those identified as important to them.

3. The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.

4. The needs of families and others identified as important to the dying person are actively explored, respected, and met as far as possible.

5. An individual plan of care, which includes food and drink, symptom control and psychological, social, and spiritual support, is agreed, coordinated, and delivered with compassion.

The five priorities are all equally important to achieving good care in the last days and hours of life.

3.3 Recognising Dying:

Recognising dying can be challenging. It often involves an element of uncertainty. It is a clinical judgement and there is no single test that can tell us if someone is dying. However, there is often evidence of the deteriorating condition and investigations may support this judgement. The dying phase can usually be recognised from a combination of the following features:

- Evidence of ongoing clinical deterioration day-by-day despite active treatment indicative that their condition is irreversible.
- Profound tiredness, fatigue, and weakness meaning the person requires help with personal care.
- Reducing mobility, becoming bed-bound, or comatose.
- Reduced interest in eating and drinking.
- Difficulty swallowing medications.
- Changes in the normal breathing pattern.
- Skin changes such as mottling due to peripheral vasoconstriction.

The assessment that a patient is in the last days of life should be made by the multidisciplinary team in discussion with the patient and their loved ones as appropriate.
There are several tools that have been developed to help clinicians identify

those patients who may be nearing the end of life. These include the **Supportive and Palliative Care Indicators Tool** (SPICT) and the **Gold Standards Framework (GSF) Prognostic Indicator Guidance**.

More information can be found here:
https://www.spict.org.uk/wp-content/uploads/2014/11/The-Supportive-and-Palliative-Care-Indicators-Tool1.pdf

https://www.goldstandardsframework.org.uk/cd-content/uploads/files/General%20Files/Prognostic%20Indicator%20Guidance%20October%202011.pdf

3.4 Communication

Once it has been recognised that someone is in the last days of life, this must be communicated and documented clearly and sensitively to the person (if they are conscious and have not indicated they would not wish to know) and their loved ones.

Communication between the team caring for the patient and their loved ones must be regular and proactive. It is important to have open, honest, and sensitive discussions.

You should ensure that communication and documentation with the individual and their loved one includes:

- **An update on the current situation** including accurate information about their prognosis (unless they do not wish to be informed), explaining any uncertainty and how this will be managed.

- **Goals of treatment and care are explained**, and a ReSPECT plan is developed with personalised recommendations including recommendation on Cadio-pulmonary resuscitation (CPR) attempts. See CP11 Resuscitation Policy attachment 6 for guidance on the completion of ReSPECT plans.

- **Preferred place of care is discussed**. If a patient has expressed a desire to be cared for in another setting in the last days of life, then it should be determined whether transfer is feasible at this stage. In hospital, initiate the ‘Rapid Home to Die’ care bundle which can be accessed via the RWT Palliative and End-of-life care intranet page.

- **Consideration of patient wishes for organ and tissue donation**. Organ donation usually occurs in the critical care or emergency department setting. However, most patients can be considered for donation of tissues (for example corneas, skin, bone, tendons, cartilage, and heart values). Each patient case will be considered on a case-by-case basis. Contact the Specialist Nurse for Organ Donation (SNOD) via 07659 137821 for further support if the patient or their loved ones express a wish to donate.

A **Care and Support in the Last Days of Life patient information leaflet** is available to give to patients and their loved ones to provide written information to support the discussions you have with them. These can be found on ward areas and are also available from the palliative care team (MI_675214).

3.5 Involving Patients and Loved Ones in Decision Making:

When developing an individual plan of care, it is important that the patient and those identified as important to them are involved in decisions around the patient's care. This includes decisions around food and drink, symptom control and psychological, social, and spiritual support. This will ensure care is coordinated and delivered with compassion.

When making decisions around care and treatment in the last days of life, clinicians must follow the principles set out by the General Medical Council (GMC) in the guideline 'Treatment and care towards the end of life: good practice in decision making' (2).

Consider the following:

A. Nutrition and hydration:

It is essential that a person's nutrition and hydration needs are assessed regularly in the last days of life (4). The dying person must be supported to eat and drink if they wish to do so.

Generally, as someone is dying, their appetite and thirst will diminish as part of a natural physiological process. It is common that in the last days of life, the dying person may not be able to take anything by mouth. For some patients and loved ones, the provision of hydration and nutrition may be seen as an essential part of care and can cause distress when it is withheld. It is important to listen to any concerns that are expressed.

There is currently insufficient evidence to inform definitive recommendations around the benefits and risks of clinically assisted hydration in the last days of life (4). Suggested benefits include helping symptoms of dry mouth, thirst, confusion, and fatigue. Potential harms include excessive respiratory secretions, oedema, and site issues for intravenous (IV) or subcutaneous (SC) infusions. It is therefore best practice to assess the dying person's hydration status at least daily, respecting the person's wishes and preferences.

If the person has distressing symptoms or signs that could be due to dehydration such as thirst, or delirium, consider a therapeutic trial of clinically assisted hydration. This should be reviewed at least every 12 hours and continue if there are signs of clinical benefit. It should be reduced or stopped if there are signs of possible harm to the dying person, or if they no longer want it.

Good and regular mouthcare remains highly important during the last days of life. Encourage loved ones to help with this if they wish to.

B. Symptom control measures:

It is essential that symptoms are assessed and managed wherever possible in accordance with the person's preferences. As a person approaches the last few days of their life, changes in their condition may lead to changes in existing symptoms, the emergence of new symptoms, or changes in the person's ability to take medicines to manage their symptoms (such as difficulty swallowing oral medicines) (4).

Prescribing medicines in anticipation can avoid a lapse in symptom control, which could otherwise cause distress for the person who is dying and those close to them. The drugs prescribed must be appropriate to the anticipated needs of the dying person and include written clinical indications (current or anticipated), dosage and routes of administration (some drugs may be prescribed for more than one indication at different doses) (4).

All medications should be reviewed regularly, adjusted as needed, and non-essential drugs should be stopped. In general, this means stopping all drugs that are not providing a symptomatic benefit.

It is paramount that the benefits and harms of any medications offered are discussed with the patient (if able to do so) and their loved ones, especially any possible sedative effects. The reason for any intervention undertaken should be explained to the dying person and those important to them. This must also be clearly documented.

There are leaflets available from the Palliative Care Team and ward areas for patients and their loved ones on Anticipatory Medications (MI_12706714) and Syringe Drivers (MI_12718514) to support these conversations.

3.6 Supporting the Dying Patient and their Loved Ones:

It is important we consider not just the clinical aspects of the dying person's care, but their spiritual, psychological, and practical needs also. Consider:

A. Spiritual needs:

Spirituality can become very important to many patients and their loved ones at the end of life. Identifying any specific religious needs can help guide appropriate chaplaincy support and may influence care after death. However, spirituality encompasses much more than religion and culture.

Irrespective of religious faith or belief, The Multifaith Chaplaincy Department can provide spiritual support to patients and their loved ones. They offer spiritual and pastoral care to those of every and no religion. To make a referral contact the team on extension 85098 or via switch out of hours for the appropriate on-call chaplain. Further information can be found on the trust intranet page.

B. Practical needs:

Where possible, offer opportunities for loved ones to spend time with the patient and offer open visiting. Investigate possible comfort measures. For example, music, own bedding, or other items from home.

Consider if the patient and loved one would prefer a side room if possible. Offer parking concessions (contact security on extension 88222). Consider if loved ones would like a guest bed to allow them to stay with the patient more comfortably. These can be requested via Teletracking, or the Palliative Care Team may be able to assist.

C. Keepsakes:

The Trust can offer keepsakes including handprints, photography, knitted hearts, and locks of hair. There are resources available in the SWAN box on each ward. Please speak to your SWAN champion or if you require further support contact the Palliative Care Team or the Bereavement Team for advice.

3.7 Planning & Doing in the Last Days of Life

It is important to review clinical decisions daily to ensure the dying person's needs are addressed. It is important to ensure:

A. **Review the need for clinical interventions and medications**. In the last days of life, it is important that the goals of care are clearly defined. The focus should be on symptom control. Elements of care that have up to this point assisted with the monitoring of the clinical condition, but are no longer contributing to comfort, should be reviewed, and discontinued unless there is a clear rationale for their ongoing requirement. This will include rationalising oral medications, measurement of vital signs, undertaking routine blood tests and IV cannulation.

   It is important there is a clear plan of care regarding personal hygiene including bowel and micturition difficulties, mobility, pressure area management, and mouth care. Regular monitoring of the dying person should be carried out to ensure good symptom control is maintained.

   As patients become weaker, they may find it increasingly difficult to take oral drugs. Where possible, essential drugs should be changed to the subcutaneous route. The use of syringe drivers, if indicated, can be useful in last days of life. They are relatively non-invasive, doses of medications can be titrated easily, and several drugs can be combined in one syringe driver to manage different symptoms.

B. **Review ReSPECT Plan (Recommended Summary Plan for Emergency Care and Treatment) including CPR recommendation.** As someone approaches the last days of life, their

priorities for clinical care and treatment in an emergency are likely to change. Included within the ReSPECT plan is a recommendation regarding whether cardiopulmonary resuscitation attempts are recommended or not. For patients who are expected to die within the next hours-days where there is no reversibility identified, CPR is almost certain to be unsuccessful and attempts are not recommended. This is a medical decision but must have been discussed with the patient (where possible) and their loved ones (unless they express a wish not to).

It is the consultant or specialist doctor in charge of the patient's care that has overall responsibility for completion of the ReSPECT plan. In their absence, the most senior doctor caring for the patient at their time (specialist registrar level or equivalent) or appropriate staff within specialist teams who have received authorship training can complete the document. However, it must then be reviewed and signed by the consultant within 72 hours.

Please consider if a patient has an implantable cardioverter defibrillator (ICD) whether the defibrillation function needs to be switched off to prevent possible shocks in the last hours of life and possible delay the person's natural death. Planned deactivation can be undertaken by the cardiac physiology team within normal working hours. In the event of the need for urgent deactivation a ring magnet can be placed and taped securely on the skin overlying the device. A ring magnet can be found on the cardiology unit (B14).

C. **Anticipatory medications are prescribed** for all patients to ensure possible common symptoms are proactively managed in the last days of life.

If the patient has **normal renal function (eGFR >30)** and the patient is opioid naïve please prescribe the following medications with the following indications:

Drug	**Dose**	**Route**	**Min. dose interval**	**Max. no. of doses in 24 hours**	**Indication**
Morphine Sulfate	2.5mg	SC	1 hour	12	Pain, breathlessness
Midazolam	2.5mg	SC	1 hour	12	Agitation/distress
Glycopyrronium	200micrograms	SC	2 hours	6	Respiratory secretions
Levomepromazine	2.5mg	SC	2 hours	6	Nausea and vomiting, agitation (second line)

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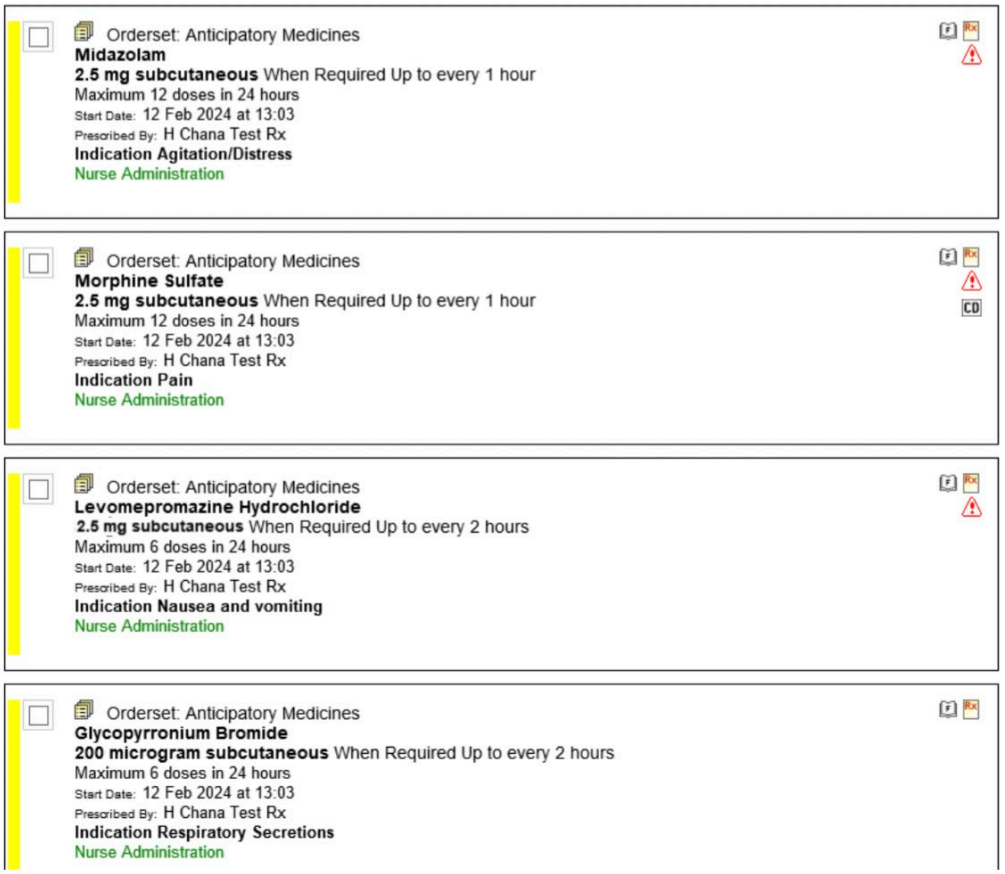
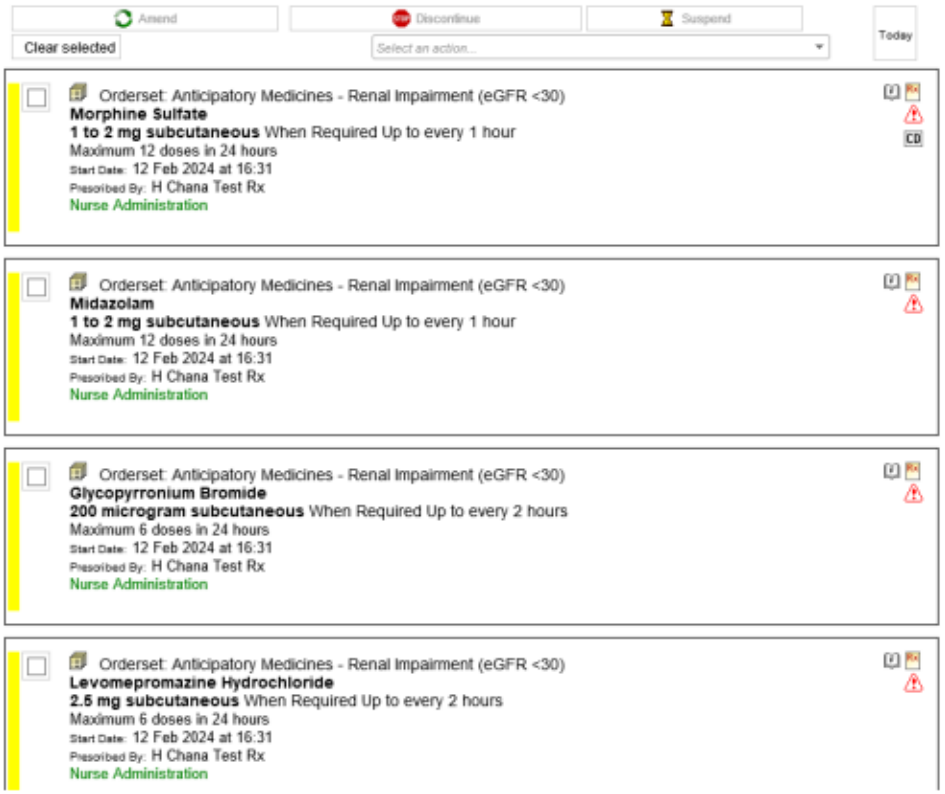
This can be found on ePMA as an order-set and will be viewed like this in the patient's record:



If the patient has **severe renal impairment (eGFR <30)** then prescribe anticipatory medications at reduced doses as below:

Drug	Dose	Route	Min. dose interval	Max. no. of doses in 24 hours	Indication
Morphine Sulfate	1-2mg	SC	1 hour	12	Pain, breathlessness
Midazolam	1-2mg	SC	1 hour	12	Agitation/distress
Glycopyrronium	200micrograms	SC	2 hours	6	Respiratory secretions
Levomepromazine	2.5mg	SC	2 hours	6	Nausea and vomiting, agitation (second line)

This can be found on ePMA as an order-set and will be viewed like this in the patient's record:



3.7.1 Prescribing anticipatory medications for end-of-life care at home.

If the patient is being discharged from hospital for end-of-life care, it is essential that anticipatory medications are included on the TTOs. When prescribing controlled drugs on the TTO medication sheet or FP10 prescription, it is a legal requirement to complete the total quantity in **WORDS and FIGURES**.

You must also complete a **Patient Specific Directive (PSD)** so these medications can be administered in the community. Please see the **Rapid Discharge Home to Die Bundle** on the Trust palliative care intranet page for copies of these and advice on how to complete.

The medications supplied and PSD required will vary depending on what area the patient's GP is in (for example, a patient who has a GP in Walsall, Dudley, or Staffordshire).

For a patient who is opioid naive, with normal renal and liver function, and is not already on a syringe driver we would advise supplying the below medications:

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Drug	Dose	Max. no. of doses in 24hrs	Route	Quantity	Indication
Wolverhampton GP Practice					
Morphine Sulfate 10mg/1ml ampoules for injection	2.5mg	12	SC	10 (TEN) x 10mg/1ml ampoules	Pain / Breathlessness
Midazolam 10mg/2ml ampoules for injection	2.5mg	12	SC	10 (TEN) x 10mg/2ml ampoules	Agitation
Levomepromazine 25mg/1ml ampoules	2.5mg	6	SC	5 x 25mg/1ml ampoules	Nausea & Vomiting
Glycopyrronium bromide 200 micrograms/1ml ampoules for injection	200 micrograms	6	SC	5 x 200 micrograms/1ml ampoules	Respiratory tract secretions
South Staffordshire GP Practice					
Morphine Sulfate 10mg/1ml ampoules for injection	2.5mg	12	SC	10 (TEN) x 10mg/1ml ampoules	Pain / Breathlessness
Midazolam 10mg/2ml ampoules for injection	2.5mg	12	SC	10 (TEN) x 10mg/2ml ampoules	Agitation
Haloperidol 5mg/1ml ampoules for injection	0.5-1mg	6	SC	5 x 5mg/1ml ampoules	Nausea & Vomiting
Hyoscine Butylbromide 20mg/1ml ampoules for injection	20mg	6	SC	5 x 20mg/1ml ampoules	Respiratory tract secretions
Walsall GP practice					
Morphine Sulfate 10mg/1ml ampoules for injection	2.5mg	12	SC	10 (TEN) x 10mg/1ml ampoules	Pain / Breathlessness
Midazolam 10mg/2ml ampoules for injection	2.5mg	12	SC	10 (TEN) x 10mg/2ml ampoules	Agitation
Levomepromazine 25mg/1ml ampoules	2.5mg	6	SC	5 x 25mg/1ml ampoules	Nausea & Vomiting
Hyoscine Butylbromide 20mg/1ml ampoules for injection	20mg	6	SC	5 x 20mg/1ml ampoules	Respiratory tract secretions
Dudley GP practice					
Morphine Sulfate 10mg/1ml ampoules for injection	2.5mg	12	SC	10 (TEN) x 10mg/1ml ampoules	Pain / Breathlessness
Midazolam 10mg/2ml ampoules for injection	2.5mg	12	SC	10 (TEN) x 10mg/2ml ampoules	Agitation
Levomepromazine 25mg/1ml ampoules	6.25mg	4	SC	5 x 25mg/1ml ampoules	Nausea & Vomiting
Glycopyrronium bromide 200 micrograms/1ml ampoules for injection	200 micrograms	6	SC	5 x 200 micrograms/1ml ampoules	Respiratory tract secretions

Shropshire GP Practice					
Morphine Sulfate 10mg/1ml ampoules for injection	2.5mg	12	SC	10 (TEN) x 10mg/1ml ampoules	Pain / Breathlessness
Midazolam 10mg/2ml ampoules for injection	2.5mg	12	SC	10 (TEN) x 10mg/2ml ampoules	Agitation
Levomepromazine 25mg/1ml ampoules	6.25mg	4	SC	5 x 25mg/1ml ampoules	Nausea & Vomiting
Hyoscine Butylbromide 20mg/1ml ampoules for injection	20mg	6	SC	5 x 20mg/1ml ampoules	Respiratory tract secretions

Please note:

- If a patient is **already taking an opioid**, you must prescribe their 'usual' as required opioid in a parental (subcutaneous) form at the appropriate breakthrough dose. If you are uncertain what opioid or dose should be prescribed, contact the Palliative Care Team for advice (ext. 85212).
- The palliative care team may make recommendations on individualised prescribing depending on a range of patient factors including impaired renal or liver function.
- The total number of ampoules for TTOs may be adjusted, at the discretion of the prescribing clinician dependent on the administration requirements (for example, if they also have a syringe driver) or circumstance (for example discharge leading up to a Bank Holiday period).

Further information can be found within the **Rapid Discharge Home to Die Bundle** for each area on the Palliative Care Team intranet page. Please contact the Palliative Care Team for further advice and support if required (ext. 85212).

3.8 Further Guidance

NICE Guideline: Care of Dying Adults in the Last Days of Life
https://www.nice.org.uk/guidance/ng31

West Midlands Palliative Care Guide
https://www.westmidspallcare.co.uk/wmpcp/

One Chance to get it Right: Improving people's experience of care in the last few days and hours of life. Leadership Alliance for the Care of Dying People
https://assets.publishing.service.gov.uk/media/5a7e301ced915d74e33f09ee/One_chance_to_get_it_right.pdf

4.0 Equipment Required

Not required.

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5.0 Training

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6.0 Financial Risk Assessment

1	Does the implementation of this document require any additional Capital resources	No
2	Does the implementation of this document require additional revenue resources	No
3	Does the implementation of this document require additional manpower	No
4	Does the implementation of this document release any manpower costs through a change in practice	No
5	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programs or allocated training times for staff.	No
	Other comments	

7.0 Equality Impact Assessment

An equality analysis has been carried out and it indicates that:

Tick	Options
X	A. There is no impact in relation to Personal Protected Characteristics as defined by the Equality Act 2010.

8.0 Maintenance

The Palliative Care Consultants will ensure this document is kept up to date and the Clinical Lead will recommend any changes / amendments.

9.0 Communication and Training

This guideline will be uploaded to the Trust intranet page and the Specialist Palliative Care Team will deliver link ward training directly to staff.

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10.0 Audit Process

The Palliative Care Directorate is responsible for undertaking an annual audit reviewing adherence to the Care in the Last Days of Life guideline as part of the National Audit of Care at the End of Life (NACEL).

Criterion	Lead	Monitoring method	Frequency	Evaluation
Case Notes Review of patients who die in hospital as part of NACEL to ensure adherence to guidelines	Clinical Lead for Palliative Care	Case Notes Review	Yearly	End of Life Steering Group

11.0 References - Legal, professional, or national guidelines must underpin policies and be referenced here. Where appropriate cross references must be made to other policies.

All references to appendices and attachments within the body of the must be highlighted in blue to enable hyperlinks to be incorporated.

1. Leadership Alliance for the Care of Dying People (2014) One Chance to Get it Right
2. General Medical Council (2010) Treatment and care towards the end of life: good practice in decision making
3. Stewart-Lord A, Baillie L, Green L, et al. Implementation and perceived impact of the SWAN model of end-of-life and bereavement care: a realist evaluationBMJ Open 2022;12:e066832. doi: 10.1136/bmjopen-2022-066832Good P, Richard R, Syrmis W, Jenkins-Marsh S, Stephens J. Medically assisted hydration for adult palliative care patients.
4. Cochrane Database of Systematic Reviews 2014, Issue 4. Art. No.: CD006273. DOI: 10.1002/14651858.CD006273.pub3.
5. NICE guideline 31 (2015) Care of Dying Adults in the Last days of life

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Part A - Document Control

Procedure/ Guidelines number and version	**Title of Procedure/Guidelines** Care in The Last Days of Life Guideline for Adult Patients (aged 18 years and above) V1.0 (Trust-Wide Guideline)	**Status:** Final		**Author:** Dr Sophie Taylor **Chief Officer Sponsor:** **Chief Medical Officer**
Version / Amendment History **Divisionally Governed Version**	**Version**	**Date**	**Author**	**Reason**
	Version 3	July 2021	Dr S Rayner	Reviewed
Trust-wide Version	Version 1 (Trust-Wide Guideline)	April 2025	Dr S Taylor	Full review and updated to Trust-wide guideline
Intended Recipients: All relevant healthcare staff				
Consultation Group / Role Titles and Date: Palliative Care Governance Meeting – 23rd October 2024 Medicines Management Group - 5th November 2024.				
Name and date of group where reviewed	Palliative Care Governance Meeting – 23rd October 2024 Medicines Management Group - 5th November 2024 Trust Policy Group – June 2025			
Name and date of final approval committee (if trust-wide document)/ Directorate or other locally approved committee (if local document)	Trust Policy Group – June 2025			
Date of Procedure/Guidelines issue	June 2025			
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated – see section 3.8.1 of Attachment 1)	Next Review June 2028, every 3 years.			

Training and Dissemination: Communicated as required through Palliative Care team.	
To be read in conjunction with: N/A	
Initial Equality Impact Assessment: Completed: Yes / ~~No~~ **Full Equality Impact assessment (as required): Completed ~~Yes / No~~ / NA** If you require this document in an alternative format e.g., larger print please contact Policy Management Officer 85887 for Trust- wide documents or your line manager or Divisional Management office for Local documents.	
Contact for Review	Dr Sophie Taylor
Monitoring arrangements	Local governance
Document summary/key issues covered. As outlined in the document	
Key words for intranet searching purposes	Care in the Last Days of Life