Appendix 1.

Criteria for Initiation of EMD EOL Management

Ensure that <u>all 5 criteria</u> below are met <u>before transfer</u> to the Quiet Room for EOL care plan

1. Actively dying patient/ High likelihood of mortality within hours to a few days
2. Family accepts that the goals of care are provision of comfort, symptom relief and dignity
3. Limitations on extent of care established and patient is not for CPR/ Intubation/ ICU transfer
4. *Family members want to stay by patient's bedside
5. Serious life-limiting illness with poor prognosis, e.g.:

   (Select one or more of the following.)

   - ☐ Chronic severe illness
     - ☐ Terminal cancer
     - ☐ End-stage Renal Failure (refused/ withdrawing dialysis)
     - ☐ Stage 4 COPD (not for intubation /NIV)
     - ☐ End-stage Cardiac disease
     - ☐ End-stage Liver disease
     - ☐ Advanced neurological disease – dementia/ PD/ CVA
     - ☐ Chronic frailty with poor functional state
   - ☐ Acute catastrophic illness (eg. Massive SAH)
   - ☐ Others (specify):_____

**If the Quiet Room is not available or family unable to stay by bedside, use the beds near the nursing counter for ease of nursing.*

Checklist for Doctors for ED EOL Care

Patient/family Communications Guidelines:

- ☐ Explain that the Quiet Room is to provide privacy and for family to spend time with their loved-one *(limited to 5 visitors, till inpatient bed is available).*
- ☐ Reassure that Drs and Nurses will review regularly, continue to provide care and administer medications in case of any pain, dyspnoea etc. *(NOT "abandonment").*
- ☐ Prepare the family for possible demise of patient and the process of deterioration *(exact timing difficult to predict, few hours to few days, not for CPR if heart stops naturally).*
- ☐ Provide the family with the "Last journey" resource booklet (booklet guide on what to do after a patient's demise) if deemed suitable.

Physician Management Decisions to be documented in ED Note:

Our patient has been identified to be actively dying or at a high risk of mortality within hours to days. The following reflects the EOL discussion initiated at the ED. Please further this process in the ward.

- ☐ Key family members identified:
    - Main spokesperson - *(Specify name & relationship)*
    - Main care giver -
- ☐ Patient involved in EOL discussion: Yes / No *(Explain eg. Patient lacks capacity)*
- ☐ MO in-charge:
- ☐ Senior ED Physician reviewing:
- ☐ Consultation:

  (Specify name/specialty eg. Dr XXX / Palliative Medicine / MICU / Oncology)

- ☐ Rationale for EOL Comfort care:

  (Describe diagnosis, prognosis, patient preferences, goals of care, previous ACP/date)
- ☐ EOL symptoms present:
    - NIL / Dyspnea / Pain / Delirium/Agitation / Secretions / Nausea/Vomiting / Fever
    - *(If present, medications given, IV/SC/NG, treatment response)*
- ☐ Medial Social Worker referral: Yes / No
- ☐ Interventions reviewed*:*
    - Lab tests: *(eg. No routine blood-taking)*
    - Parenteral fluids: *(eg. Discontinue / Maintenance drip only)*
    - Medications: *(eg. Discontinued non-essential meds, except:_____)*
    - Procedures: *(eg. Avoid IDC, NGT unless for symptomatic relief)*
    - Others:
- ☐ Any further issues to handover to ward team: *(eg persistent EOL symptoms, need for further EOL discussions, etc)*

Management of Terminal Symptoms

- Use IV route if IV access already present, dosing equivalent to SC dosing
- Use SC route if IV access not available

SYMPTOMS	SUGGESTED DRUG DOSING
Pain / Dyspnoea - Opioid-naïve patient	PO Mist morphine 2.5-5mg 4-6hrly PRN + PO Mist morphine 2.5mg PRN up to 4hrly for breakthrough
	IV/SC morphine 1-2.5 mg 4-6hrly PRN + IV/SC morphine 2mg PRN up to 4hrly for breakthrough
	Or continuous infusion IV/SC morphine 0.5-2mg/hr
Pain / Dyspnoea - For patient on oral morphine	PO Mist morphine current dose 4hrly + (1/6 of total daily dose) PRN up to 4hrly for breakthrough
	Or continuous infusion IV/SC morphine (1/3 of total daily dose of oral morphine) over 24 hrs
Pain / Dyspnoea - Renal / Liver impairment or elderly / frail patients	IV/SC fentanyl 10-30mcg bolus, followed by 1. IV/SC fentanyl 10-30mcg 2-3hrly PRN OR 2. IV/SC fentanyl infusion 10-20mcg/hr
Nausea / Vomiting	IV/SC metoclopramide 10mg 6hrly PRN (only if no intestinal obstruction)
	IV/SC haloperidol 1mg 6hrly PRN (for centrally-mediated causes eg uraemia)
Terminal Agitation (exclude urinary retention/ constipation/pain)	IV/SC haloperidol 1-2.5mg bolus, followed by 1. IV/SC haloperidol 1-2.5mg 6hrly PRN 2. IV/SC haloperidol infusion 5-10mg/24hrs
Terminal Rattling (Non-pharmacological Mx : reposition to the side/ elevate head/ mouth care)	IV/SC buscopan (hyoscine butylbromide) 20mg 6hrly PRN IV/SC glycopyrrolate 0.2mg 6hrly PRN