End of life care in Secure Psychiatric Settings

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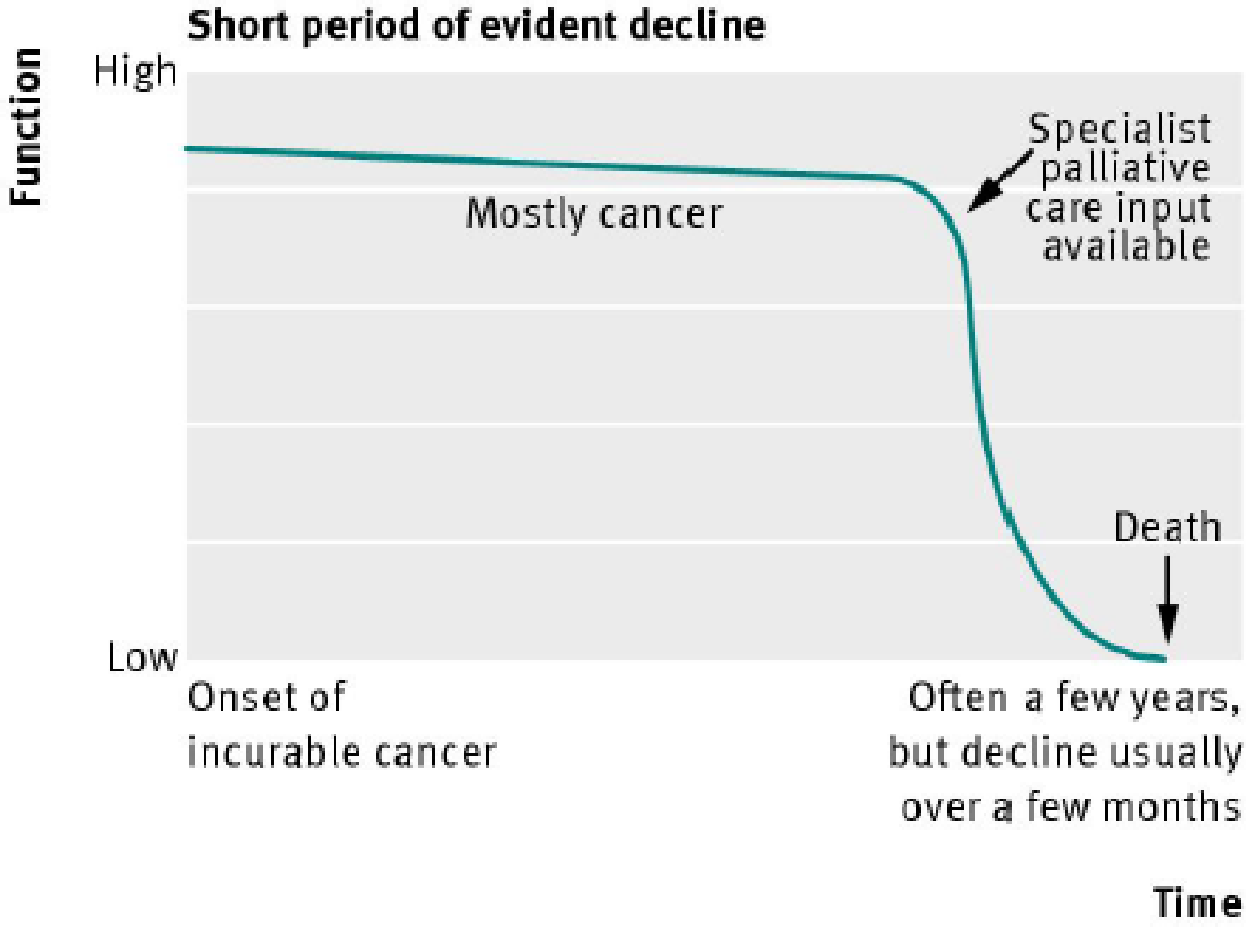
Introduction

- Terminal Illness
  - Cancer
  - Cardiovascular disease
  - Dementia

- Secure Care
  - Restrictive settings
  - Ability to use leave
  - Capacity issues

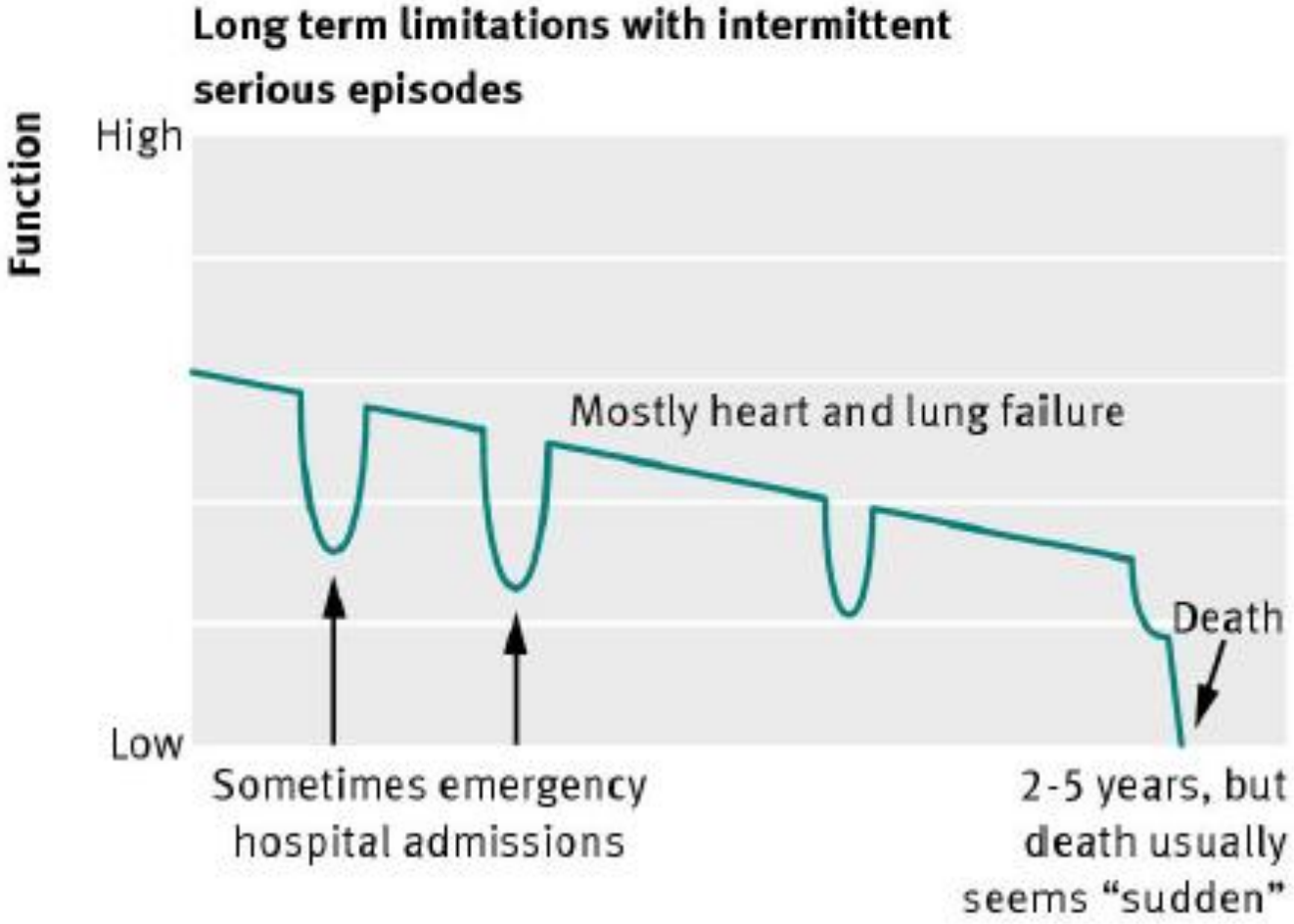
Terminal Illness

- 500,000 UK deaths per year
- 50% of people die in hospital
- Increasing number of long term patients within secure care
- Increasing need for good end of life care



Caring for a dying patient in hospital

BMJ 2013;346:f2174 doi: 10.1136/bmj.f2174 (Published 17 April 2013)



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The History and Need for Change

- “End of Life Care Strategy” Department of Health, 2008
- General Medical Council’s (GMC) guidance document on “Good Practice in Decision Making”.
- End of life pathways
  - Gold Standards Framework.
  - Liverpool Care Pathway.

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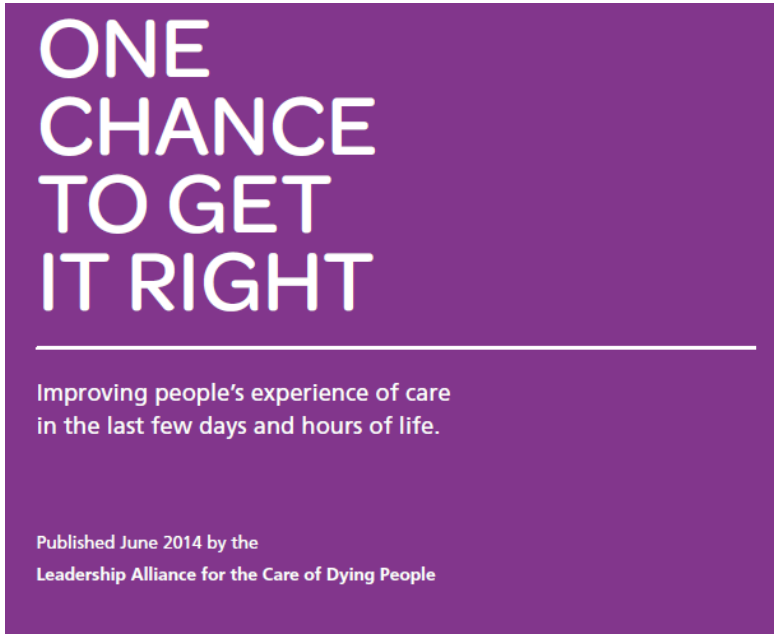
- In June 2014, The Leadership Alliance for the Care of Dying People (LACDP), *"One Chance to Get it Right."*



End of Life Care Within Psychiatric Settings

Priorities for Care of the Dying Person

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.

End of Life Care Within Psychiatric Settings

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. social and spiritual support, is agreed, co-ordinated and delivered with compassion.

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,

End of Life Care Within Psychiatric Settings

- Diagnosis of terminal illness
  - Investigations
  - Specialist referral
  - Curative / Palliative
  - Communication of diagnosis / involvement of family / chaplaincy at early stage

End of Life Care Within Psychiatric Settings

- Setting
  - Secure hospital vs transfer to hospice/ care home
  - Patient / family wishes

End of Life Care Within Psychiatric Settings

- Support
  - Physical healthcare team
  - MDT
  - GP
  - Palliative care team / nurse/ consultant
  - Accessing district nursing
  - Chaplaincy

End of Life Care Within Psychiatric Settings

- PHYSICAL HEALTH
  - Symptoms
    - Pain
    - Breathlessness
    - Nausea/ Vomiting
    - Weakness
  - DNR – CPR
    - GP/ Family / Patient

End of Life Care Within Psychiatric Settings

- Medication
  - Review / stop non essential medications
  - Oral/ subcutaneous
  - Anticipatory prescribing
  - Consider issues relevant to secure care setting e.g IV syringe drivers may not be appropriate
    - Analgesia: liaise with GP / Palliative Care Team
    - Consider oromorph / fentanyl patch

Tables

Table 1| **Reversible causes of agitation at the end of life**

Possible causes	Suggested investigations	Suggested treatments
Drugs (eg, steroids, benzodiazepines)	Review current drugs	Consider reducing dose or ceasing
Drug or alcohol withdrawal	Review social and drug history (prescribed or non-prescribed)	Consider benzodiazepines or appropriate drugs
Cancer (eg, cerebral metastases)	Review relevant scans and signs of focal neurology	Consider subcutaneous dexamethasone if prognosis >72 hours
Metabolic disorders (eg, hypercalcaemia, hypoglycaemia, hyperglycaemia)	Review most recent blood results, check capillary blood glucose	Consider treating abnormal capillary blood glucose
	Consider repeating blood tests if prognosis >72 hours	
Constipation	Examine abdomen and review bowel history	Consider rectal suppositories
Urinary retention	Examine abdomen; arrange bladder ultrasound scan	Consider urinary catheter
Pain	Observe for non-verbal signs of pain (eg, grimacing, writhing, moaning)	Prescribe appropriate analgesia
	Direct questioning if conscious	
Hypoxia	Determine oxygen saturations and respiratory rate	Consider oxygen (eg, 2-4 L/min via nasal cannula)
Infection	Take temperature, do urine dipstick, examine chest	Consider antibiotics (eg, oral suspension)

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- SOCIAL
  - Family
  - Will – solicitor / testamentary capacity
  - Funeral arrangements

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- PSYCHOLOGICAL
  - Support for patient, staff and family
  - Palliative care team
  - Effects on the inpatient team in caring for a long term patient during their end of life care

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- SPIRITUAL
  - Chaplaincy support
  - Spiritual needs
  - Funeral service

Conclusion

- Long term patients in secure care
- Need for good end of life care in secure settings in order to meet:
  - Medical
  - Psychological
  - Social
  - Spiritual needs

References and Resources

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- End-of-life care in psychiatry: ‘one chance to get it right’ Nuwan Galappathie, Sobia Tamim Khan, BJPsych Bulletin, Feb 2016; 40(1):38-40