



**DIAGNOSIS:**

**DETAILS OF LAST FAMILY/WHĀNAU MEETING**

Names of family/whānau present:

Names of ICU/hospital staff present:

Issues discussed:

Patient involved in discussion: **Yes**  **No**

ICU SMO present: **Yes**  **No**

If not present, name of ICU SMO discussed with:

**DO NOT ATTEMPT RESUSCITATION ORDERS:**

**in the event of cardiac or respiratory arrest, DO NOT PERFORM RESUSCITATION**

Do **not** perform cardiac massage, defibrillation/cardioversion or intubation

Signed:

Name (please PRINT):

Please **also** complete the ICU Treatment Goals or hospital Shared Goals of Care forms

**PROCESS CHECKLIST:**

(N/A Not Applicable)

Admitting team & patient's GP informed: **Yes**  **No**  **N/A**  Whom discussed with:

Palliative care team involvement: **Yes**  **No**  **N/A**

Spiritual/religious/cultural support required: **Yes**  **No**  **N/A**

Social work required: **Yes**  **No**  **N/A**

Coronial notification required: **Yes**  **No**  **N/A**

If **Yes**, notify family & write reason why:

Organ donation discussed (if applicable): **Yes**  **No**  **N/A**

Tissue donation considered (if age <85): **Yes**  **No**  **N/A**

Request return of tissue (e.g. bone flap): **Yes**  **No**  **N/A**

Consideration of 'Going Home To Die': **Yes**  **No**  **N/A**

PAR team informed (if required): **Yes**  **No**  **N/A**

Move to private room (if available): **Yes**  **No**  **N/A**

**Commence  
TE ARA WHAKAPIRI:**  
*Care in the last days  
of life pathway*

Specific requests by EPOA or via advanced directive for dying period

● **TREATMENT TO STOP:** (at time agreed with family/whānau)

*Respiratory support:*

Reduce ventilatory support (*please specify*):

Extubate (ETT or tracheostomy): Yes  No  N/A

Cease all supplemental oxygen therapy: Yes  No  N/A

*Cease/remove the following:*

Vasoactive medications: Yes  No  N/A

NG/PEG feed/TPN: Yes  No  N/A

Antibiotics: Yes  No  N/A

Intravenous fluids: Yes  No  N/A  (Stopping can ↓ secretions)

Insulin: Yes  No  N/A

Renal replacement: Yes  No  N/A

Intra-aortic balloon pump: Yes  No  N/A

Pacemaker: Yes  No  N/A

(if internal +/- defibrillator, consider deactivation)

*Remove the following:*

NG tube: Yes  No  N/A

Arterial line: Yes  No  N/A

Peripheral cannula(e): Yes  No  N/A

Urinary catheter: Yes  No  N/A

ICP monitor/EVD: Yes  No  N/A

Other (please specify):

● **Ensure adequate intravenous access for administration of palliative medication**

**Cease ICU documentation: use Te Ara Whakapiri documentation**

Remove & cease **ALL** monitoring (pulse oximetry, ECG, blood pressure, CVP): Yes  No

Cease **ALL** further investigations (blood tests, radiology): Yes  No

● **Review medication chart & cease all non-palliative treatment as required**

● **TREATMENT TO START:** chart symptom-specific IV PRN treatment in **AWAKE** patients:

Pain: Morphine 2.5-5 mg q1h, Fentanyl 25-50 mcg q½h

Anxiety, distress or myoclonus: Midazolam 1-3 mg q1h

Nausea, vomiting or agitated delirium: Haloperidol 0.5-1 mg q1h to max 3 mg *then*

Levomepromazine (Nozinan) 6.25-12.5 mg q4h (max 24 mg/day)

Secretions: Hyoscine Butylbromide (Buscopan) 20 mg q2h, max 120 mg/day

*Baseline opiates & benzodiazepines should be continued in all patients with previous exposure. If the patient is awake then pre-existing infusions should continue. The PRN doses above assume no previous opiate or benzodiazepine exposure. Be wary of withdrawal symptoms if infusions are ceased in any patient. All infusions should be single agent only, symptom specific, titrated to effect & discussed with medical staff prior to escalation. Please give medication to treat the patient, not their family.*

● **IF TRANSFERRING TO WARD:**

Early conversion of intravenous medications listed above into subcut route: *doses are the same*. Consider need for continuous subcut syringe driver - call Palliative Care (including out of hours) for ward dosing. Ensure hospital Goals of Care form completed. Inform family of ward visiting policy around dying. Order air mattress to transfer patient directly onto ward bed on (avoid multiple transfers).

Name (Please PRINT):

Designation:

Signature:

Date / / Time :