Intensive Care Unit AND-ICU

Allow A Natural Death in ICU

Te Whatu Ora
Health New Zealand
Capital, Coast and Hutt Valley

Surname: ..... NHI: .....
First Names:.....
Date of Birth: ...../...../..... Sex: .....
PLACE PATIENT ID HERE

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**

Continue ICU documentation until extubated, then 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 :