Recognising the dying person flow chart

Changes that can indicate dying is starting to occur:
- Profound weakness
- Reduced intake of food/fluid
- Difficulty swallowing/taking oral medications
- Bed bound after progressive decline over days and weeks
- Peripheral shut down (cold hands and feet)
- Poor improvement to medical interventions
- Near-death awareness (stories, travel, visitations)

Changes that can indicate the person is closer to death:
- Increased drowsiness/sleepiness, diminished consciousness, delirium, terminal restlessness
- Pallor of nose and top of ears, increased respiratory mandibular movements, relaxed forehead, hyperextension of neck
- Extremities cool, increased cyanosis and mottling of lips and fingers
- Cardiovascular changes (tachycardia, bradycardia, hypotension)
- Respiratory changes (persistent secretions in pharynx/trachea/bronchus, Cheyne-Stokes, apneic, atactic breathing)

Multidisciplinary team (MDT) assessment (lead health practitioner, nursing and allied health, cultural and spiritual support staff):
- Is there a potentially reversible cause for the person’s condition (e.g., exclude opioid toxicity, renal failure, hypercalcaemia, infection)?
- Has there been a poor response to medical interventions?
- Is a specialist referral needed (e.g., specialist palliative care or a second opinion)?
- Could the person be in the last days or hours of life?

Clinical decision:
- The person is NOT recognised as dying (not in the last days or hours of life):
  - Review the current plan of care
- The person IS recognised as dying (i.e., is in the last days or hours of life):
  - Explain the new or revised plan of care with the person and their family/whanau
  - Agree on the current plan of care with the person (where appropriate) and their family/whanau. Focus the discussion on recognising and understanding that the person is dying or approaching the last days of their life.

Management:
- Commence the Te Ara Whakapiri Plan of Care, including the Baseline Assessment and Ongoing Care of the Dying Person chart.

Reassessment:
- A MDT review of the current plan of care should be performed if:
  - the person’s conscious level, functional ability, oral intake, mobility, ability to perform self-care improves
  - the person, their family/whanau, carer or team member expresses concerns about the person’s management plan
  - it has been three days since the last MDT assessment.