COVID-19: ADMINISTRATION OF END-OF-LIFE DRUGS

End-of-life planning: ideas are not new but a system is needed to implement them

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In their editorial Bowers and colleagues highlight two important matters—long recognised by palliative care and primary care teams—in caring for the dying in their own home or a care home.¹ Both matters need tackling to reduce delays in getting end-of-life drugs to suffering, dying people. Delays occur while prescriptions are written and processed and drugs delivered, especially after hours and at weekends. Any delay in getting this medication to the person potentially causes unnecessary suffering, such as pain, shortness of breath, and agitation. Not good for the person and awful for their family who carry the memories of watching such suffering into bereavement.

The first matter is having a valid, up-to-date treatment escalation plan for every person identified as likely to die within the next 12 months. Such plans—which the person needs to be involved in drawing up, where appropriate—identify those for whom hospital admission as well as interventions like intravenous fluids, cardiopulmonary resuscitation, intensive care ward admission, or ventilation would not be appropriate as deterioration occurs.

The second matter is the importance of anticipatory prescribing. The authors call for central stocks of common end-of-life drugs. It makes more sense for the regulations to be changed to allow all care homes to hold a generic (rather than patient named) stock of “just-in-case” drugs (such as morphine, midazolam, haloperidol, or levomepromazine). This would both reduce delays in starting treatment as well as being considerably more cost effective than the current system.

What the editorial does not tackle is who should be leading on the implementation of such plans. These ideas are not new. We also need a system that ensures they are implemented.

Competing interests: I was a board member of the charity Compassion in Dying.