

PALLIATIVE EMERGENCIES, TREATMENT CEILINGS, AND DEATH IN THE EMERGENCY DEPARTMENT

Protocol 52: Recognition of End-of-Life and Dying; Reversible and Palliative Emergencies; Goals of Care; Treatment Escalation and DNACPR; Symptom Relief; Withholding or Withdrawal of Treatment; Expected and Unexpected Death; Bereavement; Certification; Forensic Preservation; and Mortality Review

DRAFT FOR EMERGENCY MEDICINE, NURSING, PALLIATIVE CARE, INTERNAL MEDICINE, CRITICAL CARE, PAEDIATRICS, OBSTETRICS, PHARMACY, SOCIAL WORK, CHAPLAINCY, BEREAVEMENT SERVICES, MORTUARY, SECURITY, AMBULANCE / TRANSFER SERVICES, AND CLINICAL GOVERNANCE

STATUS: This is a draft clinical-governance document. It must be reconciled with current national law, death-registration and coronial requirements, resuscitation policy, local palliative-care and pharmacy guidance, mortuary procedures, organ and tissue donation arrangements, safeguarding requirements, and available community or hospice services before approval.

CARE RULE: When cure, reversal or escalation is no longer achievable, wanted or proportionate, active care does not stop. The team must continue to relieve suffering, protect dignity, communicate honestly, support those important to the patient, and avoid abandonment.

DNACPR RULE: A decision not to attempt cardiopulmonary resuscitation applies only to CPR after cardiac arrest. It does not mean “do not treat”, and it must not by itself limit oxygen, antibiotics, fluids, analgesia, non-invasive support, ward admission, symptom relief or any other treatment that remains appropriate within the agreed goals and ceiling of care.

MEDICINE SAFETY: Any dose examples in this draft are illustrative adult starting regimens for local validation. Prescribing must be individualized for age, frailty, opioid exposure, route, renal or hepatic impairment, pregnancy, Parkinson disease, QT risk, drug interactions and the locally approved formulary. Seek specialist palliative-care and pharmacy advice whenever available.

Document control	Details
Document owner	Emergency Department / Medical Services Directorate / Nursing Services / Palliative Care / Clinical Governance
Clinical leads	Emergency Medicine; Nursing; Palliative Care; Internal Medicine; Critical Care; Paediatrics; Obstetrics; Pharmacy; Social Work; Chaplaincy; Bereavement / Mortuary; Quality and Risk
Applies to	Adults, adolescents, children and neonates presenting with advanced incurable illness, frailty, catastrophic acute illness, treatment-limitation decisions, uncontrolled end-of-life symptoms, expected or unexpected death in the Emergency Department, or need for urgent palliative disposition.
Exclusions	Routine outpatient palliative care; detailed organ-donation procedures; formal determination of death by neurological criteria; assisted dying / euthanasia; routine funeral-home or mortuary operations beyond the ED handover interface.
Interfaces	Protocols 1-8; Protocol 17 Altered Mental Status; Protocol 31 Major Trauma; Protocol 38 Obstetric Emergencies; Protocols 40-41 Paediatric / Neonatal; Protocol 42 Mental-Health Crisis; Protocol 43 Safeguarding; Protocol 45 Sickle Cell; Protocol 46 Oncology; Protocol 48 Airway; Protocol 49 Major Haemorrhage; Protocol 51 Capacity and Refusal.
Version / status	Draft 1.0 for local multidisciplinary, legal, pharmacy and governance validation
Approval date / review	Approval: _____ Review: _____ Earlier review after medication harm, disputed treatment limitation, unexpected death, forensic failure, complaint, legal change or national guidance update.
Supersedes	New protocol / existing end-of-life, DNACPR, death verification, bereavement, mortuary, coronial and organ-donation procedures to be reconciled before approval.

1. Purpose

To provide a clinically active, compassionate and legally aware pathway for recognizing serious illness and dying; distinguishing reversible emergencies from burdensome or non-beneficial intervention; establishing person-centred goals and treatment ceilings; relieving distress promptly; arranging the preferred and feasible place of care; managing expected and unexpected death; supporting families and staff; preserving evidence when required; and ensuring accurate documentation, certification, notification and mortality review.

2. Core principles

- Palliative care and emergency treatment are not opposites. A patient with advanced illness may still benefit from rapid diagnosis and treatment of a reversible problem when this is consistent with their goals.
- Use proportionality: choose interventions according to the likelihood of meaningful benefit, burden, reversibility, time to benefit, patient values and the agreed ceiling of care, not age, disability, diagnosis or bed availability alone.
- Assess and support decision-making capacity. Respect valid advance refusals and appointed decision-makers under local law. Family members provide essential knowledge and support but do not automatically become legal decision-makers.
- Communicate prognosis and uncertainty honestly, using clear language such as “dying” and “death” when appropriate. Avoid “nothing more can be done”; explain what care will now be provided.
- DNACPR concerns CPR only. Record broader treatment recommendations separately, including what should be offered as well as what should not be escalated.
- Relieve pain, breathlessness, agitation and other distress promptly. Correctly titrated opioids, anxiolytics and other symptom medicines are given to relieve suffering, not to hasten death.
- Respect cultural, spiritual and religious needs without assumptions. Offer privacy, family presence and chaplaincy / pastoral support.

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- No patient should be left alone while actively dying when family or a staff presence can reasonably be arranged.
- After death, preserve dignity, identity, property and evidence; follow local coronial, police, certification, mortuary and infection-control procedures.
- Every ED death should enter an appropriate mortality-review process that identifies good care, preventable harm and system learning.

3. Definitions

Term	Working definition
Palliative emergency	An acute event in a person with serious or life-limiting illness that causes major distress, threatens function or life, or requires urgent decision-making about reversal, palliation or both.
End-of-life care	Care and planning for a person approaching death from advanced progressive disease, frailty or catastrophic acute illness; the period may range from months or years to hours or days.
Actively dying / last hours or days	A clinical state in which death is thought likely within hours or days, while acknowledging uncertainty and the possibility of temporary stabilization.
Goals of care	The patient's values and priorities translated into an overall clinical aim, such as recovery, life prolongation with defined limits, functional preservation, comfort, or care in a preferred place.
Treatment ceiling / escalation plan	A documented, individualized statement of the highest level of clinically appropriate treatment and the interventions that should be offered, trialled, withheld or reviewed if deterioration occurs.
DNACPR	A recommendation or decision not to attempt cardiopulmonary resuscitation if cardiac or respiratory arrest occurs. It does not restrict other care.
Time-limited trial	A defined trial of treatment with agreed goals, review time, markers of benefit or harm, and a plan for continuation, modification or withdrawal.
Expected death	Death consistent with a known advanced or catastrophic condition and an established clinical trajectory / plan, subject to local legal definitions.
Unexpected / reportable death	A sudden, unexplained, violent, procedure-related, custodial or otherwise legally reportable death, or any death that does not meet the local criteria for routine certification.
Verification / pronouncement of death	The clinical confirmation and recording that death has occurred. This is distinct from certification of the medical cause of death and legal registration.
Proportionate palliative sedation	Specialist-led use of the minimum sedation necessary to relieve otherwise refractory intolerable symptoms in a dying patient. It is not routine ED sedation and is not intended to cause death.

4. Immediate triage and stabilization

FIRST QUESTION: "Is there an immediately reversible threat that the patient would want treated?" Begin ABCDE stabilization while simultaneously retrieving the patient's goals, advance plan, baseline and likely trajectory.

Finding	Immediate response
Airway obstruction, severe respiratory distress, shock, seizure, major haemorrhage, severe pain or agitation	Provide immediate proportionate treatment and symptom relief. Call senior ED help. Do not delay comfort measures while legal or prognostic information is gathered.
Known palliative patient with a new potentially reversible illness	Assess the acute problem normally, then tailor investigations and treatment to goals, likely benefit and burden. Examples include urinary retention, fracture, infection, pulmonary oedema, hypoglycaemia and medication toxicity.
Existing advance plan / DNACPR / treatment-escalation document	Obtain and validate the most current version. Confirm identity, scope, signatures / authorization, applicability to the present situation and whether the patient can now participate.
No documentation and patient lacks capacity	Treat immediate threats while urgently contacting family / legal surrogate, primary team, community palliative service or care home. Use the lawful best-interest / benefit-burden process.
Possible active dying	Move to a private, quiet space; assign a named clinician and nurse; assess symptoms, goals, family needs and reversible distress; establish an individualized care plan.
Sudden collapse with no verified treatment limitation	Begin appropriate resuscitation unless there are unequivocal signs of irreversible death, a valid applicable refusal / DNACPR under local policy, or a senior clinical determination that CPR cannot succeed.
Safeguarding, self-harm, violence, trauma, poisoning or uncertain cause	Treat and investigate appropriately. Palliative status does not remove safeguarding or forensic obligations. Preserve evidence when the death or injury may be reportable.

5. Rapid information retrieval

Information	How to obtain / use
Patient voice	Ask what matters now, what outcomes would be unacceptable, who should be involved and where the patient wishes to be cared for. Assess capacity for the decisions at hand.
Advance care plan / emergency treatment plan	Check paper documents, electronic record, care-home transfer information, ambulance documentation, primary-care record and patient-held plan.
Advance refusal / appointed decision-maker	Confirm identity, authority, scope and applicability under current local law. Seek senior / legal advice if validity or interpretation is disputed.
Baseline and trajectory	Clarify function, cognition, symptom burden, recent decline, previous admissions, prognosis discussions and prior response to treatment.
Current palliative regimen	Record regular and breakthrough opioids, benzodiazepines, antiemetics, antisecretory medicines, anticonvulsants, steroid therapy, oxygen / NIV and infusion devices.
Clinical contacts	Contact the primary specialist, palliative-care clinician, family physician, care home, oncology / renal / heart-failure team or hospice as applicable.

Information	How to obtain / use
Family / trusted persons	With consent, ask what the patient has previously said and what changes have occurred. Explain that their role is to represent the patient's values, not to carry the burden of making a purely clinical decision.
Preferred place of care / death	Determine the patient's preference and whether home, care home, hospice, ward or ED care is practically and safely achievable now.

6. Clinical classification: reversal, trial or comfort

Category	Clinical approach
A. Reversible emergency with acceptable burden	Treat actively within usual standards, with early symptom control and review of escalation preferences if deterioration occurs.
B. Potentially reversible illness with uncertain benefit	Offer a time-limited trial: define treatment, expected benefit, review time, stopping criteria and the plan if the trial fails.
C. Irreversible deterioration / likely dying	Prioritize comfort, dignity, family and spiritual support. Stop non-beneficial tests, monitoring and medicines; continue treatments that relieve symptoms or meet the patient's goals.
D. Prognosis uncertain	Acknowledge uncertainty. Seek senior and specialty / palliative input, treat readily reversible causes, reassess frequently and avoid both premature therapeutic withdrawal and burdensome escalation without a clear goal.
E. Catastrophic event with no realistic recovery	Communicate clearly, establish an immediate comfort plan, offer family presence, consider organ / tissue donation referral where relevant, and follow legal / forensic processes.

7. Goals-of-care and treatment-ceiling conversation

Step	Suggested clinical content
Prepare	Review the facts, likely outcomes and options; identify the most appropriate clinician; ensure privacy, interpreter access and time for questions.
Ask understanding	"What have you been told about the illness?" "What changes have you noticed?" "What is most important to you if time may be short?"
Share assessment	Explain the acute problem, what may be reversible, what is uncertain and the likely best- and worst-case outcomes. Use direct compassionate language.
Explore values	Ask about acceptable function, independence, suffering, place of care, family priorities, cultural / spiritual needs and previous experiences of intensive treatment.
Recommend	Offer a clinically reasoned recommendation rather than asking the patient or family to choose from an unexplained menu. State what will be done to relieve suffering.
Define ceiling	Record whether ward treatment, antibiotics, fluids, transfusion, NIV, vasopressors, intubation, ICU transfer, surgery and CPR are appropriate, inappropriate or subject to a time-limited trial.
Confirm understanding	Use teach-back. Invite questions and disagreement. Explain who will review the plan and what would trigger revision.
Communicate	Place the plan prominently in the record and handover. Share with ambulance, ward, primary / community team and family as authorized. Give the patient-held copy when used locally.

8. Capacity, advance decisions and family involvement

- Assess capacity for the specific decision and support communication as set out in Protocol 51. Pain, hypoxia, delirium, fear and medication effects may impair participation and should be treated where possible.
- A capacitous adult may accept or refuse any offered treatment, including life-sustaining treatment. The refusal should be informed, voluntary and documented.
- When the patient lacks capacity, follow valid advance refusals and the authority of any legally appointed decision-maker. Otherwise use the applicable best-interest / welfare process, considering the patient's known values and prior wishes.
- Family members and close persons should be heard and supported. They should not be told that they must "decide whether to let the patient die" when the clinical question is whether a treatment can provide benefit.
- Clinical teams are not required to offer treatment that cannot work or is judged to be non-beneficial, but decisions should be reasoned, individualized, communicated sensitively and reviewed when disputed.
- Seek a second senior opinion, ethics / legal input or urgent judicial process when disagreement is unresolved and time allows. Continue symptom relief and non-disputed care throughout.

9. CPR decisions and treatment escalation

Principle	Operational standard
CPR is a specific treatment	Discuss the likely outcome of CPR in the context of the current illness. A DNACPR decision does not determine other treatments or overall quality of care.
Document what will be provided	Record active treatments and comfort measures, not only limitations. Examples: antibiotics and ward care; NIV trial but no intubation; symptom-focused care only.
Do not use blanket criteria	Do not base decisions solely on age, disability, residence, diagnosis, frailty score, bed pressure or perceived social worth.
Existing form	Verify current applicability. If the patient's condition or wishes have changed, seek senior review and update the plan; do not casually ignore or cancel it.
No form during arrest	Follow the resuscitation algorithm while rapidly establishing relevant facts. A senior clinician may discontinue CPR when it is futile, contrary to a valid refusal, or after appropriate clinical assessment under local policy.

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Principle	Operational standard
Family presence	Offer family members the choice to be present during resuscitation when safe and feasible, with a trained staff member assigned to explain and support.
Communication after arrest	Explain plainly what happened, what was done and that the patient has died. Avoid euphemisms. Allow time, silence and questions.
Review	Reassess ceilings when the condition changes, after transfer, after a treatment trial or when the patient regains capacity.

10. Individualized end-of-life care plan in the ED

Domain	Minimum plan
Clinical goal	Recovery / time-limited trial / comfort-focused care / preferred-place transfer; expected review time.
Monitoring	Specify observations that guide comfort or a treatment trial. Stop routine monitoring that adds burden without changing care; silence unnecessary alarms.
Symptoms	Assess pain, breathlessness, nausea, agitation / delirium, secretions, seizures, bleeding, thirst, urinary retention, constipation and skin discomfort.
Medicines	Continue essential symptom medicines; stop non-beneficial preventive medicines; prescribe anticipatory PRN treatment before symptoms escalate.
Route	Use oral / buccal routes when safe. If swallowing fails, use locally approved subcutaneous or IV routes; avoid intramuscular injections unless part of an approved crisis plan.
Nursing comfort	Positioning, mouth care, continence, bladder / bowel relief, skin / pressure care, warmth, hygiene and reduced unnecessary disturbance.
Communication	Named clinician and nurse, information preferences, family contacts, interpreter, expected changes and planned review / updates.
Psychological / spiritual	Fears, unfinished concerns, religious rituals, chaplaincy / pastoral support, privacy, music, important objects and cultural needs.
Family needs	Presence, seating, refreshments, parking / practical support, involvement in care if desired, support for children and opportunity to rest.
Disposition	Home / care home / hospice / ward / ED; transport, medicines, equipment, community support and plan if symptoms worsen.

11. Non-pharmacological symptom relief

Symptom / need	Measures
Breathlessness	Sit upright or use the preferred position; calm coaching and pursed-lip breathing; cool airflow / fan when infection-control rules permit; reduce crowding and anxiety; oxygen only for symptomatic hypoxaemia or a clearly beneficial trial.
Pain	Reposition; support or splint injury; cover wounds; relieve urinary retention or constipation; provide warmth, explanation and reassurance; use a behavioural pain tool when the patient cannot self-report.
Agitation / delirium	Quiet, low-stimulation environment; familiar person; hearing / visual aids; address pain, bladder, bowel, fever, medication toxicity and other reversible causes.
Respiratory secretions	Reposition, provide mouth care, avoid burdensome deep suction; explain to family that noisy secretions often sound more distressing than they feel to the patient.
Nausea / vomiting	Identify medication, metabolic, intracranial, gastric-stasis or bowel-obstruction causes; minimize smells and movement; position safely; use cause-directed treatment.
Catastrophic bleeding	Stay with the patient; call for help and symptom medication; use dark towels, direct pressure and gentle suction when appropriate; reduce visual trauma and support family.
Thirst / dry mouth	Frequent mouth and lip care; small sips or tastes when swallowing is safe; involve family if desired. Do not equate dry mouth automatically with a need for IV fluid.
Fear / spiritual distress	Listen, acknowledge uncertainty, offer a trusted person, chaplain / faith leader, rituals and the patient's preferred music or objects.

12. Illustrative adult anticipatory medication framework

LOCAL APPROVAL REQUIRED: The table below is not a substitute for the approved hospital palliative-care formulary. Start low, titrate to observed distress, document response, and seek specialist advice for refractory symptoms, opioid conversion, organ failure, pregnancy, children or continuous infusion.

Indication	Illustrative starting approach for an opioid-naïve adult	Key safeguards
Pain / breathlessness	Morphine 1-2 mg IV or 2 mg SC, repeated at locally approved intervals according to response. Use an approved opioid-conversion plan for patients already taking opioids.	Reduce initial dose in frailty; avoid unreviewed morphine accumulation in significant renal failure; monitor comfort, sedation and respiratory pattern according to goals.
Anxiety / severe agitation	Midazolam 1-2 mg IV / SC PRN, titrated cautiously under the local pathway.	Treat pain, bladder, bowel and delirium causes first; additive sedation with opioids; do not use as a substitute for communication or staffing.
Delirium / agitation	Haloperidol 0.5-2 mg PO / IV / SC according to local guidance and patient factors.	Avoid or seek specialist advice in Parkinson disease / Lewy-body dementia; consider QT risk, seizure threshold and prior antipsychotic exposure.
Noisy respiratory secretions	Hyoscine butylbromide 20 mg SC PRN under local maximum-dose rules, or another locally approved antimuscarinic.	Reassure and reposition first; medicines reduce new secretion production but do not remove existing secretions; watch anticholinergic effects.
Nausea / vomiting	Use a cause-directed antiemetic from the local pathway, such as haloperidol, ondansetron or metoclopramide when appropriate.	Avoid metoclopramide in complete mechanical obstruction and dopamine antagonists in Parkinson disease; review QT and interactions.
Seizure / catastrophic haemorrhage distress	Use the locally approved rapid benzodiazepine / crisis plan and have medication immediately accessible.	This requires explicit governance, route / dose approval and trained staff. A crisis dose must not become a routine default order.

Indication	Illustrative starting approach for an opioid-naïve adult	Key safeguards
Repeated breakthrough symptoms	If more than 2-3 PRN doses are needed in 24 hours, obtain palliative / pharmacy review and consider a continuous SC infusion or revised background regimen.	Confirm compatibility, infusion-device competence, total prior dose, renal / hepatic function and monitoring / review plan.

13. High-distress palliative emergencies

Emergency	ED actions
Catastrophic haemorrhage / massive haemoptysis	Call senior help; stay with patient; position for airway protection and comfort; dark towels; direct pressure / topical haemostatic measures when feasible; rapid anxiolysis under approved plan; support family; consider reversible intervention only if consistent with goals.
Terminal airway obstruction / stridor	Position, oxygen if beneficial, opioid / anxiolytic symptom relief, and disease-specific treatment such as steroid, nebulized therapy or airway intervention only within the agreed ceiling. Seek ENT / anaesthesia / oncology input when reversal is realistic.
Refractory breathlessness	Treat reversible pulmonary oedema, bronchospasm, effusion, infection or anaemia when appropriate; use airflow, opioid titration and anxiety treatment. NIV may be a time-limited symptom or disease-modifying trial with explicit failure criteria.
Seizure	Protect airway and dignity; use the standard emergency seizure pathway within the ceiling; administer approved benzodiazepine and maintain anticonvulsant therapy by an alternative route when swallowing fails.
Severe pain crisis	Rapid analgesic titration; identify fracture, urinary retention, ischaemia, obstruction or other reversible cause; continue baseline opioid and prevent withdrawal; seek regional / specialist options when beneficial.
Terminal agitation / delirium	Address pain, bladder, bowel, medication toxicity, hypoxia and fear; calm environment and familiar support; proportionate antipsychotic / benzodiazepine under local guidance; specialist review for refractory distress.
Malignant bowel obstruction / persistent vomiting	Assess whether surgery, stent or decompression fits goals; otherwise use antisecretory, antiemetic and analgesic treatment under palliative / surgical guidance; avoid routine burdensome hydration if it worsens symptoms.
Implantable cardioverter-defibrillator shocks	Apply a magnet only under an approved emergency device policy and obtain cardiology / device-team advice for formal deactivation. Pacemaker function is different and must not be assumed to be disabled.

14. Hydration, nutrition and essential continuing care

- Offer food and drink for comfort when the patient wishes and can swallow safely. Reduced appetite and intake are expected as death approaches; explain this sensitively to family.
- Provide frequent mouth care regardless of hydration decisions. Small sips, ice, oral swabs and preferred tastes may relieve thirst more effectively than IV fluid.
- Consider a time-limited trial of clinically assisted hydration only when there is a plausible symptom benefit. Discuss uncertainty; monitor for benefit and harms such as pulmonary oedema, peripheral oedema, secretions, cannula burden and repeated investigations.
- Review diabetes, Parkinson disease, epilepsy, corticosteroids and other medicines where abrupt cessation may cause distress or crisis. Adjust route and dose with specialist / pharmacy advice.
- Assess urinary retention, constipation, skin integrity, pressure risk, continence, temperature and hygiene. Continue turning and pressure relief according to comfort and tolerance.
- Avoid routine blood tests, observations, injections, alarms and preventive medicines that will not influence the agreed plan.

15. Withholding or withdrawing life-sustaining treatment

Action	Standard
Decision	Base on patient wishes, valid advance plans, capacity law, clinical benefit and burden. Obtain senior and relevant specialty input; document rationale and those involved.
Equivalence	Withholding and withdrawing a treatment use the same ethical and clinical principles. A failed time-limited trial may be stopped when predefined goals are not met.
Communication	Explain what is changing, why, what symptoms may occur and what the team will do. Do not say care is being "withdrawn"; life-sustaining treatment is changing while care continues.
Preparation	Prescribe and administer symptom relief before reducing ventilatory, vasopressor or other support; ensure staff, medicines, privacy and family support are present.
Ventilation / advanced airway	Withdrawal of invasive ventilation or advanced airway support requires senior critical-care / anaesthesia involvement, a written plan and consideration of organ donation before withdrawal when applicable.
NIV / high-flow oxygen	If used for comfort, titrate to symptom benefit. If burdensome or ineffective, reduce or stop with anticipatory opioid / anxiolytic support and close bedside care.
ICD	Deactivate shock therapy when repeated shocks are inconsistent with goals, using an approved device pathway. Do not deactivate pacemaker support without specialist assessment.
Refractory distress	Seek specialist palliative input. Continuous deep sedation is not a routine ED intervention and requires clear indication, proportionality, consent / lawful decision process, monitoring and documentation.
After withdrawal	Remain present, reassess frequently, treat breakthrough distress, support family and record the time and circumstances of death when it occurs.

16. Disposition and preferred place of care

Option	Minimum requirements
Home / care home	Patient preference; symptoms controlled; safe transport; willing and informed caregiver where needed; community clinician acceptance; anticipatory medicines and administration plan; equipment; written contacts and plan if deterioration occurs.
Hospice / palliative unit	Direct clinician-to-clinician acceptance, symptom and medication handover, transport appropriate to condition, treatment ceiling / DNACPR documentation and family communication.
Hospital ward	Appropriate specialty acceptance; private environment where possible; individualized care plan and medications active before leaving ED; clear ceiling and review responsibilities.
Critical care / procedural area	Only when intervention is expected to achieve the agreed goal or as a defined time-limited trial. Avoid transfer solely because the ED lacks privacy or staffing.
Remain in ED	When death is imminent and transfer would add burden, provide a private area, named staff, continuous comfort care and family / spiritual support.
Regional transfer	Transfer only when expected benefit outweighs burden and the receiving service accepts. Provide symptom control, escort level, contingency plan and treatment ceiling during transport.

17. Care in the final hours

1. Move to the quietest private space available and place monitors in silent / privacy mode unless they guide active treatment or symptom relief.
2. Assign a named clinician and nurse and establish how often the patient will be reviewed. Include end-of-life care in every handover.
3. Explain to the patient and family, as appropriate, that death may be near and describe likely changes: increasing sleepiness, reduced intake, altered breathing, cool or mottled skin and noisy secretions.
4. Prescribe anticipatory medicines and ensure they are physically available. Reassess after every intervention and whenever family or staff perceive distress.
5. Continue mouth, skin, bladder, bowel, positioning and hygiene care. Offer family involvement without creating obligation.
6. Ask about spiritual, cultural and ritual needs; allow important objects, prayer, music and extended family presence when safe.
7. Arrange for a staff member or volunteer to remain when the patient has no family and death is imminent, where feasible.
8. Prepare the family for what will happen after death, including who verifies death, whether legal referral is required and when they may spend time with the person.

18. Family communication, presence and bereavement support

- Use a private room and a single senior spokesperson where possible. Introduce the team, sit down, use the patient's name and communicate in short clear segments.
- When death occurs, say plainly: "I am very sorry. [Name] has died." Pause. Allow silence, emotion and questions; repeat information as needed.
- Offer family presence during resuscitation when safe and supported by a dedicated staff member. Respect a choice not to be present.
- Ask whether the family wishes to see or spend time with the person after death. Explain tubes, wounds or post-mortem changes before viewing.
- Offer interpreter, chaplaincy / faith leader, social work, culturally appropriate rituals and age-appropriate support for children. Avoid euphemisms that can confuse children.
- Provide written information on immediate next steps, property, certification / legal processes, mortuary / funeral arrangements, support services and who to contact with later questions.
- Consider keepsakes only with explicit family consent and when legally / forensically permissible.
- Offer a follow-up contact or bereavement meeting after sudden or complex death under the local pathway. Document concerns requiring an earlier clinical, governance or complaint response.

19. Expected death in the ED

Step	Required action
Confirm plan	Verify identity, diagnosis / trajectory, treatment ceiling, capacity / advance plan and that expected death criteria are met under local policy.
Care before death	Continue active symptom management, privacy, family presence, spiritual support and regular clinical review. Do not abandon the patient after a comfort decision.
At death	A trained clinician verifies death using the approved process and records the date, exact time, findings and name / role. Distinguish verification from certification of cause.
Notifications	Inform senior ED clinician, nursing lead, responsible specialty / primary clinician, family / next of kin and other services required by local policy.
Certification / registration	Determine who can complete the medical certificate of cause of death and whether the death must be referred to the Coroner, police, Registrar or another authority. Do not promise routine certification until eligibility is confirmed.
Donation	Follow local organ / tissue referral criteria without allowing donation considerations to influence treatment-limitation decisions.
After-death care	Respect culture and infection precautions; identify and label correctly; manage property; complete mortuary handover; provide family information and document all actions.
Review	Include the death in ED mortality review and end-of-life quality audit, even when expected.

20. Unexpected, sudden or potentially forensic death

FORENSIC RULE: When death is sudden, unexplained, violent, related to trauma, poisoning, self-harm, restraint, custody, a procedure, possible neglect, maternal / child circumstances or other reportable condition, preserve the body, clothing, devices, specimens, records and property exactly as required by the local Coroner / police pathway. Do not wash, remove tubes or discard items unless authorized or clinically necessary.

Step	Required action
Resuscitation record	Document arrival condition, times, rhythm, interventions, medicines, procedures, response, decision to stop, persons present and senior review.
Scene / evidence	Minimize unnecessary handling; retain clothing and personal effects; leave lines, tubes and drains in place unless the authorized investigator directs otherwise; secure specimens and packaging with chain of custody.
Identification	Use two identifiers and the hospital unknown-patient process when needed. Never rely solely on family visual identification for legal purposes unless local procedure permits.
Notification	Notify the senior ED clinician and nurse immediately; activate Coroner / police / safeguarding / occupational / public-health or other statutory pathways as applicable.
Family	Provide compassionate factual information without speculation about cause or blame. Explain that legal referral may delay release or limit contact with the body.
Body access	Coordinate viewing with investigating authorities. Protect dignity while avoiding alteration of evidence.
Records	Secure contemporaneous notes, ECGs, imaging, laboratory results, drug ampoules / infusion data and device downloads when relevant. Do not retrospectively alter entries; add dated clarifications.
Staff	Conduct an immediate operational debrief for safety and welfare, followed by formal incident and mortality review.

21. Verification, certification and legal referral

Issue	Standard
Verification of death	Performed by a clinician authorized and trained under local policy, after the required assessment / observation period. Record findings, date and time. The time of verification may differ from the estimated time death occurred.
Medical cause-of-death certificate	Completed only by an eligible medical practitioner who can state the cause to the required legal standard. Use the locally prescribed form and terminology.
Coroner / police referral	Refer every death meeting current statutory criteria, including uncertain or unnatural cause, trauma, poisoning, possible crime, neglect, custody / restraint, procedure-related death or other mandated category.
Registrar notification	Follow the Registration of Births, Deaths and Marriages process and approved hospital workflow. Provide the family with accurate instructions and avoid giving legal advice beyond the service pathway.
Stillbirth / neonatal / maternal death	Use the correct statutory definitions and forms; notify obstetric, neonatal, paediatric, safeguarding and mortality-review systems as required.
Confidentiality after death	Continue to protect confidential information while sharing what is lawful and necessary with family, investigators, registration authorities and reviewing bodies.
Disputed cause / documentation	Do not guess or provide a speculative cause. Escalate to the Coroner / responsible authority and document the uncertainty and advice received.

22. Children, neonates, pregnancy and other high-impact deaths

- Use age-specific resuscitation, symptom dosing and communication. Obtain paediatric / neonatal and pharmacy input; adult anticipatory doses in this protocol must not be applied to children.
- Include parents / guardians and the child or young person to the extent appropriate, while following local capacity, assent, safeguarding and parental-authority law.
- After a child or neonatal death, provide a senior clinician and nurse, a private environment, clear explanation, memory-making options where appropriate, and dedicated bereavement follow-up. Activate mandatory child-death review and safeguarding processes.
- Maternal collapse or death requires simultaneous obstetric, anaesthetic, neonatal and critical-care response, mandatory maternal-death reporting and sensitive support for the newborn and family.
- Death after self-harm, overdose, violence, abuse or trafficking requires the relevant mental-health, safeguarding, forensic and statutory pathway, with suicide-bereavement support where applicable.
- For people without identified family, experiencing homelessness, in custody, or from migrant / marginalized groups, ensure equal dignity, identification efforts, lawful notification and culturally appropriate support.

23. Staff support and learning after death

- Hold a brief hot debrief after difficult or unexpected deaths to address immediate safety, unanswered tasks, team communication and staff welfare. A debrief is not a blame or evidentiary investigation.
- Offer protected support after child death, violence, suicide, catastrophic haemorrhage, prolonged resuscitation, moral conflict or cases that closely affect staff personally.
- Use a short respectful pause after resuscitation when appropriate, without delaying legal, clinical or family responsibilities.
- Review all ED deaths through the approved mortality-review system. Complete urgent incident escalation for suspected preventable harm, treatment-delay, medication error, disputed limitation, safeguarding failure or forensic breach.

- Share learning with the ED team and track improvement actions to completion. Include examples of excellent communication and compassionate care, not only errors.

24. Documentation standard

- Presenting illness, baseline, trajectory, relevant prognostic information and reversible causes considered.
- Capacity, communication support, patient goals, advance documents, legal surrogate and family / clinician contacts.
- Goals-of-care discussion: information given, uncertainty, patient values, recommendation, questions and agreement / disagreement.
- Specific treatment ceiling: interventions to offer, time-limited trials, review points, DNACPR status and who authorized / reviewed the plan.
- Symptom assessments, non-pharmacological care, medicines / doses / routes, response, adverse effects and specialist advice.
- Preferred and actual place of care; transfer / discharge acceptance, medicines, equipment, transport and community support.
- If treatment is withheld or withdrawn: clinical rationale, patient / surrogate involvement, senior review, symptom plan and events after change.
- Family communication, presence, interpreter, spiritual / cultural requests, viewing, bereavement information and concerns raised.
- Death verification: clinician, findings, date and time; certification eligibility; Coroner / police / Registrar / donation / mortuary notifications and advice received.
- Unexpected death: full resuscitation record, evidence preservation, property, chain of custody, incident report, debrief and mortality-review referral.

25. Staff roles

Role	Responsibilities
Triage / reception	Recognize severe distress and known end-of-life plans; prioritize assessment; confirm contact details and retrieve patient-held documents.
Primary nurse	Provide comfort and observations appropriate to goals; anticipate symptoms; support family; document response; maintain privacy, mouth / skin / continence care and after-death procedures.
Treating clinician	Assess reversibility, capacity and prognosis; lead goals discussion; establish ceiling and care plan; prescribe symptoms treatment; coordinate disposition and death documentation.
Senior ED clinician	Review uncertainty, disputed decisions, treatment withdrawal, unexpected death, legal referral and incident escalation; ensure handover and governance completion.
Palliative-care team	Provide complex symptom, opioid conversion, infusion, refractory distress, communication, discharge and bereavement support.
Critical care / anaesthesia / specialty team	Advise on realistic benefit, time-limited trials, withdrawal of advanced support, device management and organ-donation referral.
Pharmacist	Validate formulary, conversions, renal / hepatic adjustments, infusion compatibility, discharge supply and safe anticipatory prescribing.
Social work / chaplaincy / bereavement	Support emotional, practical, spiritual, cultural, safeguarding and post-death needs; assist children and isolated patients / families.
Mortuary / pathology / Coroner-police liaison	Receive lawful handover, preserve identification and evidence, advise on reportability, certification and release processes.
Clinical governance	Maintain policy, training, quality dashboard, medication review, mortality review, complaints / duty-of-candour processes and improvement actions.

26. Quality and safety indicators

Measure	Suggested local standard / review
Recognition	Time from arrival to recognition of likely dying; proportion of ED deaths in which dying was recognized before death.
Care plan	Proportion of patients recognized as dying with documented goals, treatment ceiling, symptom plan and preferred place of care.
Symptom relief	Time to first analgesic / breathlessness / agitation treatment; reassessment after medication; unplanned repeated rescue doses.
Communication	Patient and family informed of prognosis when appropriate; interpreter and spiritual needs addressed; named clinician / nurse documented.
Disposition	Time to palliative / hospice consultation; proportion discharged or transferred to preferred place when safely feasible; avoidable transfers near death.
DNACPR quality	DNACPR documented separately from broader treatment plan; no evidence that DNACPR inappropriately limited other care.
After death	Verification and notifications complete; donation referral considered; property and mortuary handover accurate; bereavement information provided.
Mortality review	All ED deaths identified; expected timeframe for multidisciplinary review; actions tracked; themes shared with staff.
Equity	Audit care by age, disability, diagnosis, ethnicity, socioeconomic status, residence, communication needs and time of attendance.
Experience / harm	Complaints, medication incidents, disputed ceilings, forensic breaches, family feedback and staff wellbeing themes reviewed.

27. Training and simulation

- All ED clinicians and nurses receive training in recognizing dying, goals-of-care communication, capacity, DNACPR / escalation plans, core symptom relief, death verification, bereavement and forensic preservation.
- Annual simulation should include: advanced frailty with sepsis and uncertain benefit; metastatic cancer with catastrophic haemorrhage; NIV withdrawal after failed trial; opioid-naïve terminal breathlessness; disputed family request for non-beneficial CPR; sudden child death; and unexpected death requiring police / Coroner referral.
- Medication competency must include opioid conversion hazards, renal impairment, SC route, infusion-device use, Parkinson / QT cautions, paediatric exclusion and management of over-sedation.
- Joint drills should include nursing, palliative care, pharmacy, critical care, chaplaincy, mortuary, security and governance staff.
- Communication and bereavement training should include interpreters, children, cultural humility, family presence during resuscitation and staff support.

28. Local configuration required before approval

- ☐ Current national capacity, advance decision, DNACPR, death-verification, certification, Coroner, police, registration and confidentiality requirements reviewed by legal / governance leads.
- ☐ Saint Christopher and Nevis Coroners Act and Registration of Births, Deaths and Marriages Act requirements reconciled with current amendments and hospital procedure.
- ☐ Authorized roles and exact clinical process for verification / pronouncement of death defined.
- ☐ Eligibility and workflow for completing the Medical Certificate of Cause of Death defined, including after-hours arrangements.
- ☐ Reportable-death criteria, police / Coroner contacts, evidence-preservation and chain-of-custody process approved.
- ☐ Palliative-care consultation, after-hours advice, hospice / home-care / care-home and regional-transfer pathways defined.
- ☐ Adult, paediatric, neonatal, pregnancy, renal and hepatic symptom-medication pathways approved by pharmacy and therapeutics committee.
- ☐ Subcutaneous medication, syringe-pump, controlled-drug, anticipatory discharge supply and infusion-compatibility procedures approved.
- ☐ Treatment-escalation / DNACPR form and electronic display standardized; ambulance and community interoperability tested.
- ☐ ICD deactivation / magnet policy and organ / tissue donation referral arrangements defined.
- ☐ Private end-of-life / bereavement space, equipment trolley, family information, interpreter and chaplaincy access established.
- ☐ Mortuary, property, viewing, infection-control, cultural / religious and funeral-home handover procedures approved.
- ☐ Child, neonatal, maternal, suicide, custody and other mandatory mortality-review pathways defined.
- ☐ ED mortality-review timetable, quality indicators, staff-support pathway and responsible leads assigned.

29. Source guidance for local adaptation

Source	Key use in this protocol
Royal College of Emergency Medicine. End of Life Care Toolkit, updated May 2025.	Recognition, goals and treatment escalation, DNACPR distinction, symptom care, continuing nursing care, spiritual / emotional support, bereavement, environment and audit standards.
NICE. Care of Dying Adults in the Last Days of Life (NG31), current guidance.	Recognition and uncertainty, communication, shared decisions, individualized care, hydration, anticipatory prescribing, symptom treatment and specialist escalation.
NICE. End of Life Care for Adults: Service Delivery (NG142), current guidance.	Advance care planning, coordinated services, carer support, treatment review, preferred place, multiprofessional and out-of-hours care.
Resuscitation Council UK. Ethics Guidelines 2025; ReSPECT resources and 2026 policy briefing.	Person-centred emergency planning, ethical decision-making, family presence during resuscitation, CPR recommendations and accessible emergency treatment plans.
General Medical Council. Treatment and Care Towards the End of Life: Good Practice in Decision Making.	Dignity, capacity, advance decisions, clinically appropriate treatment, communication, treatment withdrawal and professional responsibilities.
Royal College of Emergency Medicine. Mortality Reviews in the Emergency Department, 2025.	Routine review of ED deaths, standardized judgement, monthly reporting, learning and governance.
Saint Christopher and Nevis. Coroners Act, Ch. 3:08; Registration of Births, Deaths and Marriages Act, Ch. 12:13, publicly available consolidated editions.	Local legal framework for reportable deaths, inquests, registration and medical certification; current amendments and operational interpretation require formal validation.
Current Ministry / hospital policy, pharmacy formulary, organ / tissue donation system and mortuary procedure.	Controlling local authority for medication, roles, forms, legal notifications, evidence, certification, transport, release and post-death care.

Annex A. One-page palliative emergency and dying workflow

Stage	Action
1. Stabilize	ABCDE; relieve severe pain, breathlessness, agitation, seizure or bleeding immediately. Treat readily reversible threats while obtaining goals and plans.
2. Retrieve	Patient voice, capacity, advance plan, DNACPR / escalation document, proxy, baseline, trajectory, medicines, primary / palliative contacts and preferred place.
3. Classify	Reversible emergency; time-limited trial; likely dying; catastrophic irreversible event; or uncertain. Seek senior / specialty input.
4. Discuss	Explain illness and uncertainty; explore values; recommend a goal; define treatments to offer and ceiling; document CPR separately.
5. Plan comfort	Private space, named clinician / nurse, anticipatory medicines, non-drug care, monitoring only if useful, family and spiritual support.
6. Treat symptoms	Pain / breathlessness / nausea / agitation / secretions / seizure / bleeding; titrate and reassess. Specialist review for refractory distress.
7. Decide place	Home / care home / hospice / ward / ED / critical care according to preference, benefit, support and transport burden.

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Stage	Action
8A. Expected death	Verify under local policy; notify family and services; determine certification / Coroner pathway; donation consideration; dignified after-death care.
8B. Unexpected death	Full resuscitation record; preserve evidence; notify senior, Coroner / police and safeguarding; compassionate factual family communication.
9. Support	Viewing, written bereavement information, spiritual / cultural care, property, follow-up contact and staff debrief.
10. Learn	Mortality review for every ED death; urgent incident review for suspected harm, dispute, medication or forensic failure.

Annex B. Goals-of-care and treatment-escalation record

Field	Record
Patient / encounter	Name _____ DOB _____ number _____ date / time _____
Capacity / decision-maker	Capacity present <input type="checkbox"/> absent <input type="checkbox"/> uncertain <input type="checkbox"/> proxy / surrogate / basis _____
Advance documents	Advance plan <input type="checkbox"/> advance refusal <input type="checkbox"/> DNACPR <input type="checkbox"/> treatment escalation <input type="checkbox"/> none found <input type="checkbox"/> location / validity _____
Clinical situation / trajectory	_____
What may be reversible	_____
Patient values / priorities	_____
Overall goal	Recovery <input type="checkbox"/> time-limited trial <input type="checkbox"/> function <input type="checkbox"/> comfort <input type="checkbox"/> preferred-place care <input type="checkbox"/> other _____
Treatments to provide	Ward care <input type="checkbox"/> antibiotics <input type="checkbox"/> fluids <input type="checkbox"/> transfusion <input type="checkbox"/> NIV <input type="checkbox"/> surgery / procedure <input type="checkbox"/> ICU <input type="checkbox"/> symptom care <input type="checkbox"/> other _____
Treatments not appropriate / refused	Intubation <input type="checkbox"/> vasopressors <input type="checkbox"/> ICU <input type="checkbox"/> surgery <input type="checkbox"/> CPR <input type="checkbox"/> other _____
Time-limited trial	Treatment _____ goal / marker _____ review time _____ stop / change criteria _____
Symptom plan	Pain _____ breathlessness _____ agitation _____ nausea _____ secretions _____
Preferred / planned place	Home <input type="checkbox"/> care home <input type="checkbox"/> hospice <input type="checkbox"/> ward <input type="checkbox"/> ED <input type="checkbox"/> critical care <input type="checkbox"/> regional transfer <input type="checkbox"/>
People involved	Patient <input type="checkbox"/> family / trusted person <input type="checkbox"/> interpreter <input type="checkbox"/> palliative <input type="checkbox"/> specialty <input type="checkbox"/> senior ED <input type="checkbox"/> legal / ethics <input type="checkbox"/>
Review / handover	Next review _____ triggers _____ receiving / community clinician _____
Clinician / senior	Clinician _____ senior reviewer _____ signature / time _____

Annex C. End-of-life symptom and comfort checklist

- ☐ Private / quiet space and alarms minimized; named clinician and nurse identified.
- ☐ Pain assessed by self-report or behavioural tool; reversible causes treated; analgesia prescribed and reassessed.
- ☐ Breathlessness: position / airflow / calm coaching; hypoxaemia assessed; opioid / anxiolytic and disease-specific treatment as appropriate.
- ☐ Agitation / delirium: pain ☐ bladder ☐ bowel ☐ medication ☐ metabolic ☐ fear ☐ environment ☐ reviewed; treatment prescribed.
- ☐ Nausea / vomiting and obstruction cause considered; safe antiemetic plan active.
- ☐ Respiratory secretions explained; repositioning / mouth care; antimuscarinic available if needed.
- ☐ Seizure / catastrophic bleed crisis plan and immediately available medicines when relevant.
- ☐ Oral route reviewed; SC / IV route authorized; IM avoided unless approved crisis plan.
- ☐ Opioid exposure, renal / hepatic function, Parkinson disease, QT risk, pregnancy and paediatric status checked.
- ☐ Food / drink for comfort, mouth care, bladder / bowel, pressure / skin, continence, warmth and hygiene addressed.
- ☐ Family / interpreter / chaplaincy / cultural or spiritual needs and support for children addressed.
- ☐ Reassessment interval and escalation for refractory distress documented.

Annex D. Expected death and after-death checklist

- ☐ Identity confirmed with two identifiers; expected trajectory and treatment plan verified.
- ☐ Death verified by authorized clinician: name / role _____ date _____ time _____.
- ☐ Clinical verification findings documented using approved form / policy.
- ☐ Family / next of kin informed by _____ at _____; interpreter / support offered.
- ☐ Responsible specialty / primary clinician / senior ED / nurse in charge notified.
- ☐ Certification eligibility confirmed; Medical Certificate of Cause of Death pathway assigned to _____.
- ☐ Coroner / police referral required? yes ☐ no ☐ uncertain ☐ Advice / reference _____.
- ☐ Organ / tissue donation referral considered / completed / not applicable, according to local system.
- ☐ Tubes / devices / body care handled according to expected-death, infection and cultural procedure.
- ☐ Property inventoried and released / secured; documentation and signatures complete.
- ☐ Mortuary / funeral-home transfer authorization, identity labels and handover complete.
- ☐ Family viewing, spiritual rituals, written bereavement information and follow-up contact offered.
- ☐ Death entered into mortality-review and quality-audit system.

Annex E. Unexpected / forensic death response card

Step	Completion
1. Senior alert	Senior ED clinician _____ nurse in charge _____ time _____.
2. Resuscitation record	Arrival / collapse _____ rhythms _____ procedures / drugs _____ stop decision / reviewer _____.
3. Preserve	Body and scene protected <input type="checkbox"/> tubes / lines left <input type="checkbox"/> clothing / property secured <input type="checkbox"/> specimens / ampoules retained <input type="checkbox"/> .
4. Identify	Two identifiers / unknown-patient process: _____.
5. Notify	Coroner _____ police _____ safeguarding _____ public health _____ specialty _____ other _____ reference _____.
6. Family	Informed by _____ at _____; factual explanation <input type="checkbox"/> legal process explained <input type="checkbox"/> viewing restrictions explained <input type="checkbox"/> .
7. Evidence	Chain-of-custody owner _____ items / specimens _____.
8. Records	Notes secured <input type="checkbox"/> ECG / imaging / labs <input type="checkbox"/> device data <input type="checkbox"/> CCTV / access request if lawful <input type="checkbox"/> .
9. Body handover	Authorized destination _____ receiving person _____ date / time _____.
10. Governance	Incident report _____ hot debrief _____ staff support _____ mortality / serious-event review owner _____.

Annex F. Local legal, clinical and operational configuration table

Item	Approved local rule / contact / document location
Capacity / advance refusal / surrogate law	_____
Treatment-escalation / DNACPR form and approval	_____
24-hour palliative-care / hospice advice	_____
Adult anticipatory medication guideline	_____
Paediatric / neonatal palliative medication guideline	_____
SC route / syringe pump / controlled-drug process	_____
Critical-care treatment withdrawal policy	_____
ICD deactivation / magnet procedure	_____
Organ / tissue donation referral	_____
Verification-of-death authorized roles / procedure	_____
Medical certificate of cause-of-death process	_____
Coroner / police referral criteria and contacts	_____
Registrar / death-registration process	_____
Forensic evidence / chain-of-custody procedure	_____
Mortuary / funeral-home / property handover	_____
Child / neonatal / maternal / suicide / custody death review	_____
Bereavement, chaplaincy, interpreter and family follow-up	_____
ED mortality-review lead and timetable	_____