Academy of Aid-in-Dying Medicine
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Instructions/checklist for staff managing PEG administration of medical aid in dying:

Attending/prescribing provider name and contact information:

In case the above provider is unavailable, backup/alternative provider name and contact information:

Note to prescribers: Before selecting the PEG route, evaluate the PEG tube by considering the reason for placement, insertion site, type (low-profile button or standard), and lumen size. If the lumen diameter is less than 20 Fr, the recommended protocol is to replace the tube to reduce the risk of medication-induced occlusions, as smaller lumens are more susceptible to clogging.

3-7 days before the planned procedure:

1. Instruct the patient and family on planning and preparing:
    - Constipation or loose stools must be carefully managed, using medications if needed. The goal is to have a formed, easily passed bowel movement every 3-5 days to ensure the aid-in-dying medications are easily absorbed.
    - Any nausea or vomiting must be well managed for 72 hours, preferably with non-sedating medications. Before proceeding, the patient should have been able to tolerate small amounts of intake in the past 24 hours.
    - Continue all medications, including comfort medications, unless otherwise ordered by the attending provider.
    - The patient must be able to self-administer 60mL of fluid into their PEG tube by depressing the plunger on a feeding syringe or releasing a clamp, using their teeth or another preferred mechanism. The patient should practice self-administration to ensure they can do so easily. (NOTE: We do not recommend using a pump of any kind, due to the high risk of clogging and jamming.)
    - Another person can assist with preparing the medications and anchoring the catheter if necessary.
    - Patients must be sufficiently oriented to communicate an understanding of their terminal disease, prognosis, and their end-of-life options, including aid-in-dying, to proceed.
    - Patients can change their minds at any point and choose not to proceed with aid-in-dying, and it is perfectly normal to adjust plans.
    - Facility staff, caregivers, or short-term rental owners should generally be aware that this individual is likely to die soon, though the details about how or why can stay private.
    - The patient should stop intake after midnight the night before the procedure, except for clear liquids.
    - Patients may feel more comfortable wearing an incontinence brief in case of urination but are unlikely to pass stool.
    - Ideally, the procedure should be initiated in the morning to allow time for attendance.
    - Discuss who will prepare the medications. If staff are required not to touch these dangerous medications, consider referring to end-of-life doulas or volunteers who may. If loved ones must manage this, explain how to do so safely. (See below.)
    - Discuss who may remain at the bedside during the ingestions until the patient is deeply comatose. If staff are required to leave the room during these critical moments, consider referring to end-of-life doulas or volunteers for this essential care.
    - Sitting upright during administration can help prevent coughing, and it is recommended to stay upright until sedation begins to take effect.
    - The 2 oz of liquid medication can cause a slight burning sensation, which will pass quickly once sedation begins.

- Once the sedation takes effect, the patient can be gently laid down on their left side (to improve absorption), and the family can come in close for comfort.
- Typically, the time to sleep and enter a deep coma is 5-10 minutes, and the time to death is around 2 hours, but may range from 1 day to 10 minutes. Reassure patients and families that once in a deep coma, the patient will not experience any discomfort.
- The patient's lips may become blue, their face may become pale, and their jaw may relax. There may be slight stiffening and relaxation of the body, followed by sudden deep breathing, which can then stabilize and become shallow for several hours.
- Staff should plan to stay at least until the patient is deeply comatose and the family is sufficiently comfortable and knows whom to call if concerns arise or reassurance is needed.
- The patient's heart and lungs will slow down and stop. Death can be determined once there is no detectable neck pulse and no breath for over 10 minutes.
- A hospice nurse visit can be provided whenever needed, including once the patient has died, for post-mortem care.

2. Prepare and update contingency plans with patients and their families in case the patient loses capacity or aid in dying is not clinically advisable. These plans should detail who will provide bedside attendant care, the typical signs and symptoms to expect, the care that may be needed, and which medications might be beneficial.
3. Assess the PEG tube: reason for placement, insertion site, type (low-profile button or standard), and lumen size. If the lumen diameter is less than 20 Fr, the recommended protocol is to replace the tube to lower the risk of medication-induced occlusions, as smaller lumens are more prone to clogging.
4. Assess GI function: intake, output, symptoms (N/V, bowel sounds, constipation, diarrhea, ascites), and the use of medications that may impact gastrointestinal absorption or function.
5. Assess cognition: orientation, use of comfort or other sedating medications, ability to understand and communicate terminal disease, prognosis, and end-of-life options, including aid-in-dying.
6. Assess the patient's ability to self-administer 60mL of fluid into their PEG tube using their preferred method.
7. Once the medications are on hand, inspect them, verify the Rx (DDMAPH, patient's name, and DOB), and ideally store them in the lockbox until needed, for safety. Confirm all necessary supplies are also on hand (syringes, clamps, feeding bags, apple juice, etc.).
8. Call the prescribing provider or their backup and report the patient's plans for ingestions (if any), assessment findings, and review medications to continue or discontinue before the procedure.
9. Do not proceed with planning aid in dying (call prescriber) if the patient
   - has uncontrolled nausea, vomiting, or signs of bowel obstruction or gastroparesis, including severe nausea and vomiting.
   - Is not tolerating intake for at least 24 hours, or has no bowel sounds + no BM in over 5 days.
   - Unable to easily administer medications into their PEG tube by depressing a syringe plunger or releasing a clamp.
   - The patient has permanently lost capacity and cannot communicate a clear understanding of their disease, prognosis, end-of-life options, including aid-in-dying.

<u>1 day before the planned procedure:</u>

1. Verbally confirm that the patient wants to proceed and understands they do not have to.
2. Ensure all necessary supplies are on hand. (see above)
3. Review what to expect on the day of the procedure. (see above)
4. Review contingency plans.
5. Assess GI function: intake, output, symptoms (N/V, bowel sounds, constipation, diarrhea, ascites), and medications.

6. Assess cognition: orientation, use of comfort or other sedating medications, ability to understand and communicate disease, prognosis, and end-of-life options, including aid-in-dying.
7. Assess the patient's ability to self-administer in the preferred manner.

The day of the planned death, upon arrival :

1. Verbally confirm that the patient wishes to proceed with plans to take the medications to die, and that they understand they can change plans at any time.
2. Also, verbally confirm they are sufficiently oriented, can swallow, and have maintained a NPO/clear liquids only status since midnight.
3. Review what to expect with the patient and family (see above).
4. Prepare medications to a total volume of 2 oz/60mL (unless otherwise instructed). Then, place a barrier, put on masks, and gloves. Pour 45 mL of clear, filtered apple juice directly into the medication bottle, cap it, and shake it for at least 30 seconds. Then, decant this suspension into a cup and draw it up into a 60 mL catheter-tipped syringe. Next, pour an additional 10-15 mL of filtered apple juice into the cup and draw it into the syringe, filling it to a total volume of 2 oz/60 mL, being careful not to overfill, and cap it.
    a. Note: If a high dose of DDMAPH is ordered, dilute to a total of 90mLs, and use one non-sterile 100mL catheter-tipped syringe. These are readily available for purchase.
5. Place the filled syringe, tip/cap-side up, into the graduated cylinder, keeping the tip upright to prevent blockage, as medications tend to clump in the tip.
6. Clean up and dispose of any contaminated materials in a plastic bag and store it out of easy reach for later cleanup.
7. Bring capped tip-up medications in the graduated cylinder, along with any other additional supplies to the bedside.

During self-administration

1. Have the Patient sit upright if possible or lie on their left side.
2. Hold the filled capped syringe tip up and shake vigorously for 30 seconds.
3. Uncap the syringe and insert it into the catheter or decant it into the clamped feeding bag.
4. Anchor the patient's PEG if needed.
5. Instruct the patient that they may proceed by depressing the plunger or releasing the clamp when they are ready.
6. Once the patient has fully self-administered the medications, clamp or cap the PEG; no further flush is required.
7. Note the time of ingestion and the time of full sedation to report later to the attending provider.
8. Once sedation has begun, lie the patient down on their left side (to improve absorption).
9. Support the family by encouraging them to gather close for comfort. Normalize signs of the dying process, while reassuring them that the patient is deeply in a coma and is comfortable.
10. Once the patient has been unconscious for at least 30 minutes and the family is settled, staff may clean up and depart.
11. Rinse any contaminated containers, including the medication bottle, and remove any labels. Dispose of the bottle, syringes, graduated cylinder, and other contaminated materials in a plastic bag, then place it in the outdoor bin (not in the kitchen trash).
12. Request hospice triage to call every 2-3 hours and remind the family to call hospice once the patient has died (no neck pulse and no breathing for over 10 minutes) or at any time they need support.

~reviewed and updated 10/2025