

Hospice Name:

Name: Unit no: DOB:

Care of the Dying Pathway (lcp)

(Hospice)

References:

Working Party on Clinical Guidelines In Palliative Care (1997) Changing Gear – Guidelines for Managing the Last Days of Life in Adults. National Council for Hospice and Specialist Palliative Care Services, London (revised and reprinted January 2005)

Ellershaw JE, Wilkinson S (2003) Care of the dying: A pathway to excellence. Oxford: Oxford University Press.

Instructions for use

1. All goals are in **heavy** typeface. Interventions, which act as prompts to support the goals, are in normal type.
2. The palliative care guidelines are printed on the pages at the end of the pathway. Please make reference as necessary.

Practitioners are free to exercise their own professional judgement, however, any alteration to the practice identified within this LCP must be noted as a variance on the sheet at the back of the pathway.

Criteria for use of the LCP

All possible reversible causes for current condition have been considered:

The multiprofessional team has agreed that the patient is dying, and two of the following may apply: -

- | | |
|---|---|
| The patient is bedbound <input type="checkbox"/> | Semi-comatose <input type="checkbox"/> |
| Only able to take sips of fluids <input type="checkbox"/> | No longer able to take tablets <input type="checkbox"/> |

Consultant: Named nurse: Ward:



Name: Unit no: Date/Time commenced:

Section 1 Initial assessment																																	
Diagnosis & Demographics	<p>PRIMARY DIAGNOSIS:..... SECONDARY DIAGNOSIS:.....</p> <p>Date of In-patient admission:..... Ethnicity:.....</p> <p>DOB:..... NHS no:..... Female <input type="checkbox"/> Male <input type="checkbox"/></p>																																
Physical condition	<table border="0"> <tr> <td>Unable to swallow</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>Aware</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> <tr> <td>Nausea</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>Conscious</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> <tr> <td>Vomiting</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>UTI problems</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> <tr> <td>Constipated</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>Catheterised</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> <tr> <td>Confused</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>Respiratory tract secretions</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> <tr> <td>Agitation</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>Dyspnoea</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> <tr> <td>Restless</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>Pain</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> <tr> <td>Distressed</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>Other (e.g. oedema, itch)</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> </table>	Unable to swallow	Yes <input type="checkbox"/> No <input type="checkbox"/>	Aware	Yes <input type="checkbox"/> No <input type="checkbox"/>	Nausea	Yes <input type="checkbox"/> No <input type="checkbox"/>	Conscious	Yes <input type="checkbox"/> No <input type="checkbox"/>	Vomiting	Yes <input type="checkbox"/> No <input type="checkbox"/>	UTI problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Constipated	Yes <input type="checkbox"/> No <input type="checkbox"/>	Catheterised	Yes <input type="checkbox"/> No <input type="checkbox"/>	Confused	Yes <input type="checkbox"/> No <input type="checkbox"/>	Respiratory tract secretions	Yes <input type="checkbox"/> No <input type="checkbox"/>	Agitation	Yes <input type="checkbox"/> No <input type="checkbox"/>	Dyspnoea	Yes <input type="checkbox"/> No <input type="checkbox"/>	Restless	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pain	Yes <input type="checkbox"/> No <input type="checkbox"/>	Distressed	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other (e.g. oedema, itch)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Unable to swallow	Yes <input type="checkbox"/> No <input type="checkbox"/>	Aware	Yes <input type="checkbox"/> No <input type="checkbox"/>																														
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Comfort measures	<p>Goal 1: Current medication assessed and non essentials discontinued Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Appropriate oral drugs converted to subcutaneous route and syringe driver commenced if appropriate. Inappropriate medication discontinued.</p> <p>Goal 2: PRN subcutaneous medication written up for list below as per protocol (See sheets at back of LCP for guidance)</p> <table border="0"> <tr> <td>Pain</td> <td>Analgesia</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> <tr> <td>Agitation</td> <td>Sedative</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> <tr> <td>Respiratory tract secretions</td> <td>Anticholinergic</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> <tr> <td>Nausea & vomiting</td> <td>Anti-emetic</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> <tr> <td>Dyspnoea</td> <td>Anxiolytic / Muscle relaxant</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> </table> <p>Goal 3: Discontinue inappropriate interventions</p> <table border="0"> <tr> <td>Blood test (including BM monitoring)</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/></td> </tr> <tr> <td>Antibiotics</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/></td> </tr> <tr> <td>I.V.'s (fluids/medications)</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/></td> </tr> <tr> <td>Not for cardiopulmonary resuscitation recorded (Refer to hospice Policy for guidance)</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> </table> <p>.....</p> <p>Deactivate cardiac defibrillators (ICD's) Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/></p> <p>Contact patient's Cardiologist Refer to local policy and procedures Information leaflet given to patient / carer if appropriate</p> <p>Doctor's signature: Date:</p> <p>Goal 3a: Decisions to discontinue inappropriate nursing interventions taken Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Routine turning regime – reposition for comfort only – consider pressure relieving mattress – & appropriate assessments re skin integrity - taking vital signs If BM monitoring in place reduce frequency as appropriate e.g. once daily</p> <p>Goal 3b: Syringe driver set up within 4 hours of doctors order Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/></p> <p>Nurse signature: Date: Time:.....</p>	Pain	Analgesia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Agitation	Sedative	Yes <input type="checkbox"/> No <input type="checkbox"/>	Respiratory tract secretions	Anticholinergic	Yes <input type="checkbox"/> No <input type="checkbox"/>	Nausea & vomiting	Anti-emetic	Yes <input type="checkbox"/> No <input type="checkbox"/>	Dyspnoea	Anxiolytic / Muscle relaxant	Yes <input type="checkbox"/> No <input type="checkbox"/>	Blood test (including BM monitoring)	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Antibiotics	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	I.V.'s (fluids/medications)	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Not for cardiopulmonary resuscitation recorded (Refer to hospice Policy for guidance)	Yes <input type="checkbox"/> No <input type="checkbox"/>									
Pain	Analgesia	Yes <input type="checkbox"/> No <input type="checkbox"/>																															
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Name: Unit no: Date:

Section 1	Initial assessment - Continued		
Psychological/ Insight	Goal 4: Ability to communicate in English assessed as adequate a) Patient Yes <input type="checkbox"/> No <input type="checkbox"/> Comatosed <input type="checkbox"/> b) Family/other Yes <input type="checkbox"/> No <input type="checkbox"/>		
	Goal 5: Insight into condition assessed Aware of diagnosis a) Patient Yes <input type="checkbox"/> No <input type="checkbox"/> Comatosed <input type="checkbox"/> b) Family/other Yes <input type="checkbox"/> No <input type="checkbox"/> Recognition of dying c) Patient Yes <input type="checkbox"/> No <input type="checkbox"/> Comatosed <input type="checkbox"/> d) Family/other Yes <input type="checkbox"/> No <input type="checkbox"/>		
Religious/ Spiritual support	Goal 6: Religious/spiritual needs assessed a) with Patient Yes <input type="checkbox"/> No <input type="checkbox"/> Comatosed <input type="checkbox"/> b) with Family/other Yes <input type="checkbox"/> No <input type="checkbox"/> Patient/other may be anxious for self/others Consider specific cultural needs Consider support of Chaplain/Religious adviser Religious tradition identified, if yes specify: Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Support of Chaplain/Religious adviser offered Yes <input type="checkbox"/> No <input type="checkbox"/> In-house support Tel/bleep no:Name:..... Date/time: External support Tel/bleep no:Name:..... Date/time: Comments (Special needs now, at time of impending death, at death & after death identified)		
Communication with family/other	Goal 7: Identify how family/other are to be informed of patient's impending death Yes <input type="checkbox"/> No <input type="checkbox"/> At any time <input type="checkbox"/> Not at night-time <input type="checkbox"/> Stay overnight at hospice <input type="checkbox"/> Primary contact name: Relationship to patient:..... Tel no: Secondary contact: Tel no:.....		
	Goal 8: Family/other given hospice information on:- Yes <input type="checkbox"/> No <input type="checkbox"/> Facilities leaflet available to address: Car parking; Accommodation; Beverage facilities; Payphones; Washrooms & toilet facilities on the ward; Visiting times; Any other relevant information.		
Communication with primary health care team	Goal 9: G.P. Practice is aware of patient's condition Yes <input type="checkbox"/> No <input type="checkbox"/> G.P. Practice to be contacted if unaware patient is dying; message can be left with the receptionist		
Summary	Goal 10: Plan of care explained & discussed with: a) Patient Yes <input type="checkbox"/> No <input type="checkbox"/> Comatosed <input type="checkbox"/> b) Family/other Yes <input type="checkbox"/> No <input type="checkbox"/>		
	Goal 11: Family/other express understanding of planned care Yes <input type="checkbox"/> No <input type="checkbox"/> Family/other aware that the planned care is now focused on care of the dying & their concerns are identified & documented. The LCP document may be discussed as appropriate		
If you have charted "No" against any goal so far, please complete variance sheet on the back page.			
Health Professional signature: Title: Date:			



Name: Unit no: Date:

Codes (please enter in columns) A= Achieved V=Variance (not a signature)

<i>Section 2</i>	<i>Patient problem/focus</i>	04:00	08:00	12:00	16:00	20:00	24:00
Ongoing assessment							
Pain							
Goal: Patient is pain free							
<ul style="list-style-type: none"> ● Verbalised by patient if conscious ● Pain free on movement ● Appears peaceful ● Consider need for positional change 							
Agitation							
Goal: Patient is not agitated							
<ul style="list-style-type: none"> ● Patient does not display signs of delirium, terminal anguish, restlessness (thrashing, plucking, twitching) ● Exclude retention of urine as cause ● Consider need for positional change 							
Respiratory tract secretions							
Goal: Excessive secretions are not a problem							
<ul style="list-style-type: none"> ● Medication to be given as soon as symptoms arise ● Consider need for positional change ● Symptom discussed with family/other 							
Nausea & vomiting							
Goal: Patient does not feel nauseous or vomits							
<ul style="list-style-type: none"> ● Patient verbalises if conscious 							
Dyspnoea							
Goal: Breathlessness is not distressing for patient							
<ul style="list-style-type: none"> ● Patient verbalises if conscious. ● Consider need for positional change. 							
Other symptoms (e.g. oedema, itch)							
.....							
Treatment/procedures							
Mouth care							
Goal: Mouth is moist and clean							
<ul style="list-style-type: none"> ● See mouth care policy ● Mouth care assessment at least 4 hourly ● Frequency of mouth care depends on individual need ● Family/other involved in care given 							
Micturition difficulties							
Goal: Patient is comfortable							
<ul style="list-style-type: none"> ● Urinary catheter if in retention ● Urinary catheter or pads, if general weakness creates incontinence 							
Medication (If medication not required please record as N/A)							
Goal: All medication is given safely & accurately							
<ul style="list-style-type: none"> ● If syringe driver in progress check at least 4 hourly according to monitoring sheet 							
Signature							

Repeat this page 24 hrly. Spare copies on Ward
If you have charted "V" against any goal so far, please complete variance sheet on the back page



Name: Unit no: Date:

Codes (please enter in columns) A= Achieved V=Variance (not a signature)

<i>Section 2</i>	<i>Patient problem/focus</i>	04:00	08:00	12:00	16:00	20:00	24:00
Ongoing assessment Pain Goal: Patient is pain free <ul style="list-style-type: none"> • Verbalised by patient if conscious • Pain free on movement • Appears peaceful • Consider need for positional change 							
Agitation Goal: Patient is not agitated <ul style="list-style-type: none"> • Patient does not display signs of delirium, terminal anguish, restlessness (thrashing, plucking, twitching) • Exclude retention of urine as cause • Consider need for positional change 							
Respiratory tract secretions Goal: Excessive secretions are not a problem <ul style="list-style-type: none"> • Medication to be given as soon as symptoms arise • Consider need for positional change • Symptom discussed with family/other 							
Nausea & vomiting Goal: Patient does not feel nauseous or vomits <ul style="list-style-type: none"> • Patient verbalises if conscious 							
Dyspnoea Goal: Breathlessness is not distressing for patient <ul style="list-style-type: none"> • Patient verbalises if conscious. • Consider need for positional change. 							
Other symptoms (e.g. oedema, itch)							
Treatment/procedures Mouth care Goal: Mouth is moist and clean <ul style="list-style-type: none"> • See mouth care policy • Mouth care assessment at least 4 hourly • Frequency of mouth care depends on individual need • Family/other involved in care given 							
Micturition difficulties Goal: Patient is comfortable <ul style="list-style-type: none"> • Urinary catheter if in retention • Urinary catheter or pads, if general weakness creates incontinence 							
Medication (If medication not required please record as N/A) Goal: All medication is given safely & accurately <ul style="list-style-type: none"> • If syringe driver in progress check at least 4 hourly according to monitoring sheet 							
Signature							

Repeat this page 24 hrly. Spare copies on Ward
If you have charted "V" against any goal so far, please complete variance sheet on the back page



Name: Unit no: Date:

Codes (please enter in columns) A= Achieved V=Variance (not a signature)

<i>Section 2</i>	<i>Patient problem/focus</i>	04:00	08:00	12:00	16:00	20:00	24:00
Ongoing assessment Pain Goal: Patient is pain free <ul style="list-style-type: none"> • Verbalised by patient if conscious • Pain free on movement • Appears peaceful • Consider need for positional change 							
Agitation Goal: Patient is not agitated <ul style="list-style-type: none"> • Patient does not display signs of delirium, terminal anguish, restlessness (thrashing, plucking, twitching) • Exclude retention of urine as cause • Consider need for positional change 							
Respiratory tract secretions Goal: Excessive secretions are not a problem <ul style="list-style-type: none"> • Medication to be given as soon as symptoms arise • Consider need for positional change • Symptom discussed with family/other 							
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Other symptoms (e.g. oedema, itch)							
Treatment/procedures Mouth care Goal: Mouth is moist and clean <ul style="list-style-type: none"> • See mouth care policy • Mouth care assessment at least 4 hourly • Frequency of mouth care depends on individual need • Family/other involved in care given 							
Micturition difficulties Goal: Patient is comfortable <ul style="list-style-type: none"> • Urinary catheter if in retention • Urinary catheter or pads, if general weakness creates incontinence 							
Medication (If medication not required please record as N/A) Goal: All medication is given safely & accurately <ul style="list-style-type: none"> • If syringe driver in progress check at least 4 hourly according to monitoring sheet 							
Signature							

Repeat this page 24 hrly. Spare copies on Ward
If you have charted "V" against any goal so far, please complete variance sheet on the back page



Name: Unit no: Date:

Section 3 Verification of death

Date of death: Time of death:

Persons present:

Notes:

Cause of death

Signature: Time verified:

Care after death	Goal 12: GP Practice contacted re patient's death Date ___/___/___ Yes <input type="checkbox"/> No <input type="checkbox"/> <ul style="list-style-type: none"> ● If out of hours contact on next working day ● Message can be left with receptionist
	Goal 13: Procedures for laying out followed according to hospice policy Yes <input type="checkbox"/> No <input type="checkbox"/> <ul style="list-style-type: none"> ● Carry out specific religious / spiritual / cultural needs - requests
	Goal 14: Procedure following death discussed or carried out Yes <input type="checkbox"/> No <input type="checkbox"/> Check for the following: <ul style="list-style-type: none"> ● Explain mortuary viewing as appropriate ● Family aware cardiac devices (ICD's) or pacemaker must be removed prior to cremation ● Post mortem discussed as appropriate. ● Input patients death on hospice computer
	Goal 15: Family/other given information on hospice procedures Yes <input type="checkbox"/> No <input type="checkbox"/> <ul style="list-style-type: none"> ● Hospice information booklet given to family/other about necessary legal tasks
	Goal 16: Hospice policy followed for patient's valuables & belongings Yes <input type="checkbox"/> No <input type="checkbox"/> <ul style="list-style-type: none"> ● Belongings and valuables are signed for by identified person ● Property packed for collection ● Valuables listed and stored safely
	Goal 17: Necessary documentation & advice is given to the appropriate person Yes <input type="checkbox"/> No <input type="checkbox"/> <ul style="list-style-type: none"> ● Death certificate signed ● Need for cremation certificate explained (2 doctors to sign) ● Coroner notified when necessary ● Aid with funeral expenses (assisted as identified)) ● Confirm understanding of need to register death ● 'What to do after death' booklet given (DHSS), if applicable ● Hospice leaflet given (registering a death)
	Goal 18: Bereavement leaflet given Yes <input type="checkbox"/> No <input type="checkbox"/> <ul style="list-style-type: none"> ● Information leaflet on grieving and local support given ● Bereavement support forms completed
	<p>If you have charted "No" against any goal so far, please complete variance sheet at the back of the pathway before signing below</p> <p>Health Professional signature: Date:</p> <p style="text-align: center;">Have you completed the last 4 & 12 hourly observation</p>



Name: Unit no: NHS no:

Variance analysis

What Variance occurred & why?	Action Taken	Outcome
Signature..... Date/Time.....	Signature..... Date/Time.....	Signature..... Date/Time.....
Signature..... Date/Time.....	Signature..... Date/Time.....	Signature..... Date/Time.....
Signature..... Date/Time.....	Signature..... Date/Time.....	Signature..... Date/Time.....
Signature..... Date/Time.....	Signature..... Date/Time.....	Signature..... Date/Time.....
Signature..... Date/Time.....	Signature..... Date/Time.....	Signature..... Date/Time.....

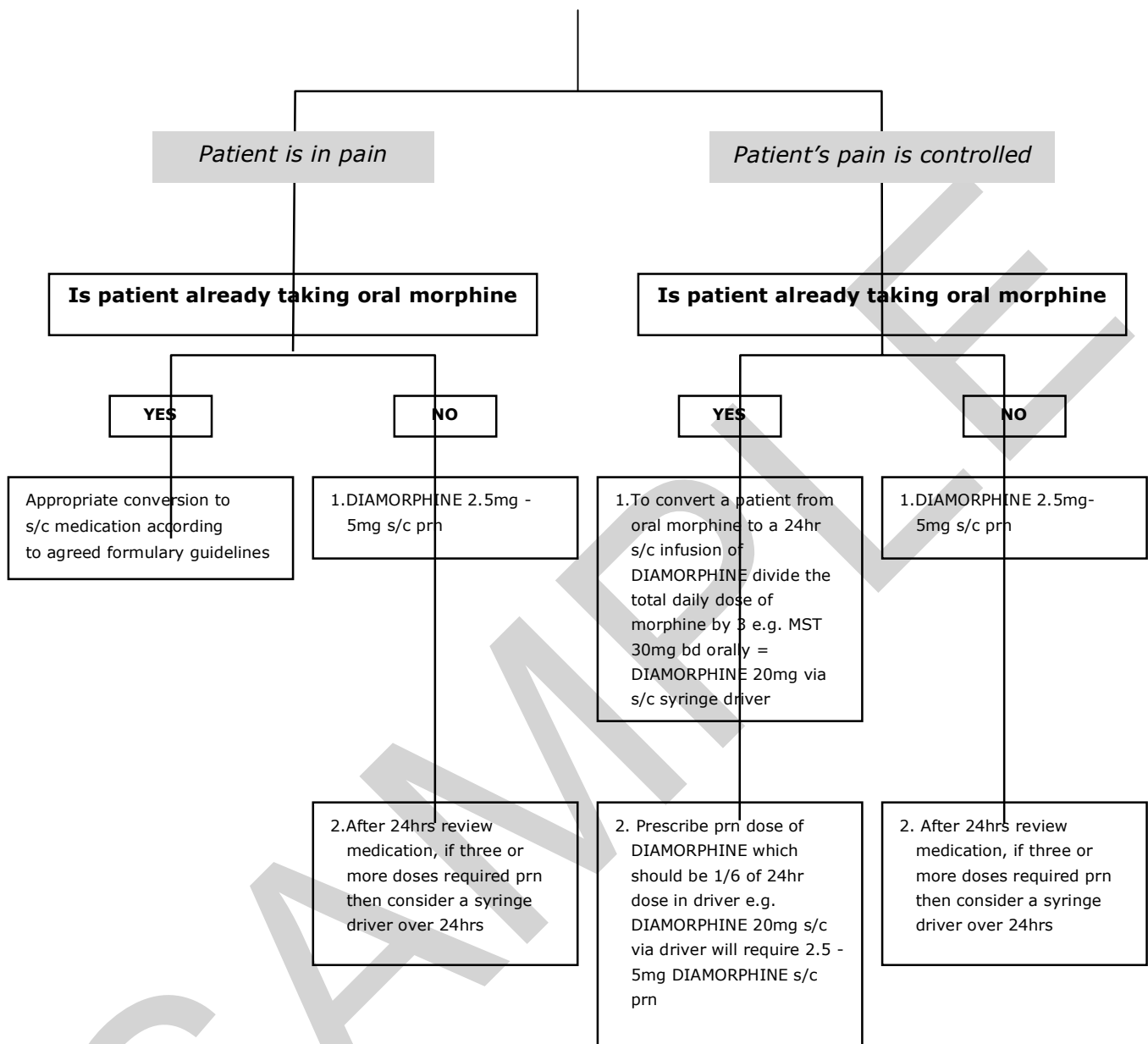


Name: Unit no: NHS no:

Variance analysis

What Variance occurred & why?	Action Taken	Outcome
Signature..... Date/Time.....	Signature..... Date/Time.....	Signature..... Date/Time.....
Signature..... Date/Time.....	Signature..... Date/Time.....	Signature..... Date/Time.....
Signature..... Date/Time.....	Signature..... Date/Time.....	Signature..... Date/Time.....
Signature..... Date/Time.....	Signature..... Date/Time.....	Signature..... Date/Time.....
Signature..... Date/Time.....	Signature..... Date/Time.....	Signature..... Date/Time.....

Pain

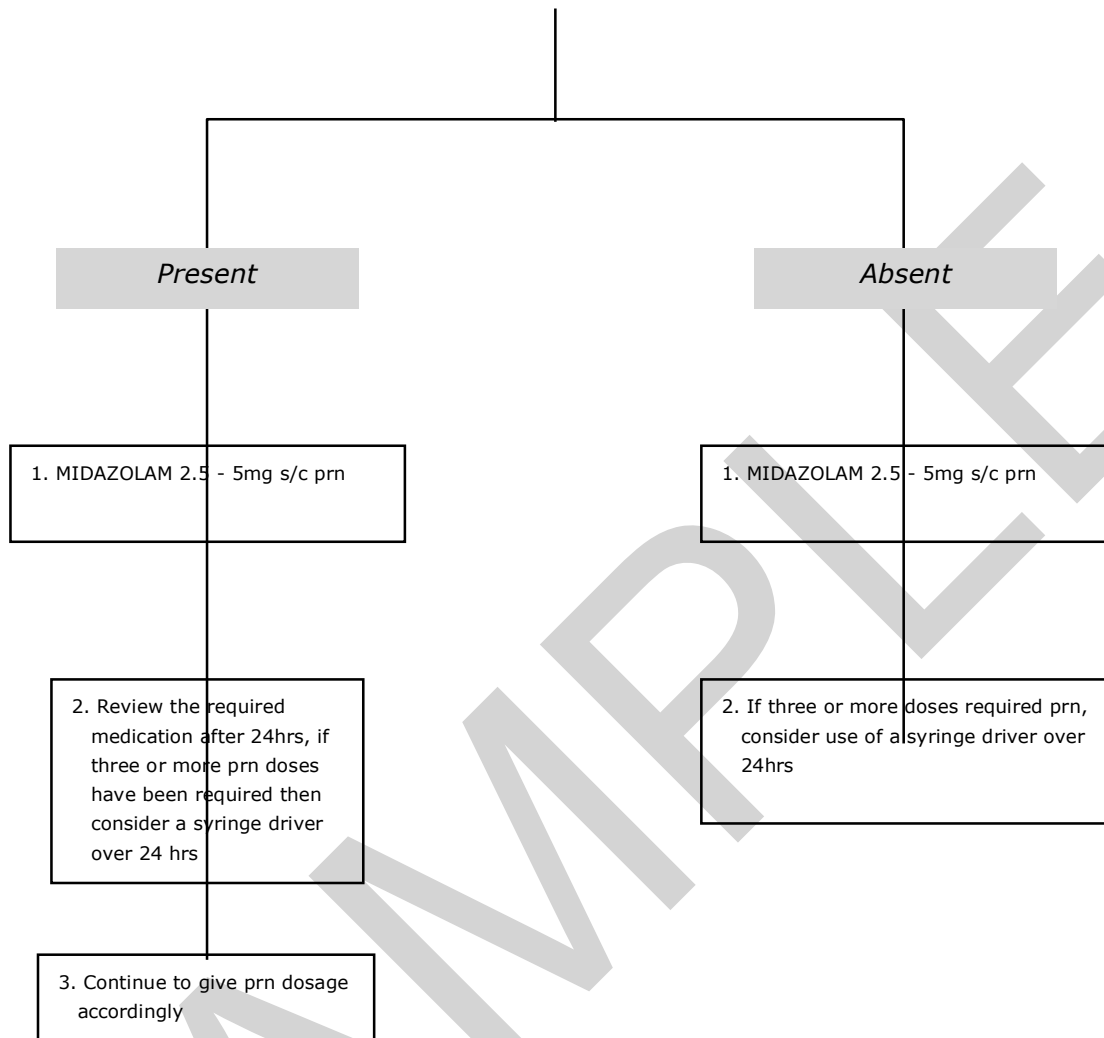


SUPPORTIVE INFORMATION:

- To convert from other strong opioids refer to agreed formulary & standards & guidelines
- Morphine 5 – 10mg s/c prn may be utilized as an alternative
- Anticipatory prescribing in this manner will ensure that in the last hours / days of life there is no delay responding to a symptom if it occurs.
- *These guidelines are produced according to local policy & procedure & you may want to alter them for local use and reference them accordingly*



Terminal restlessness and agitation

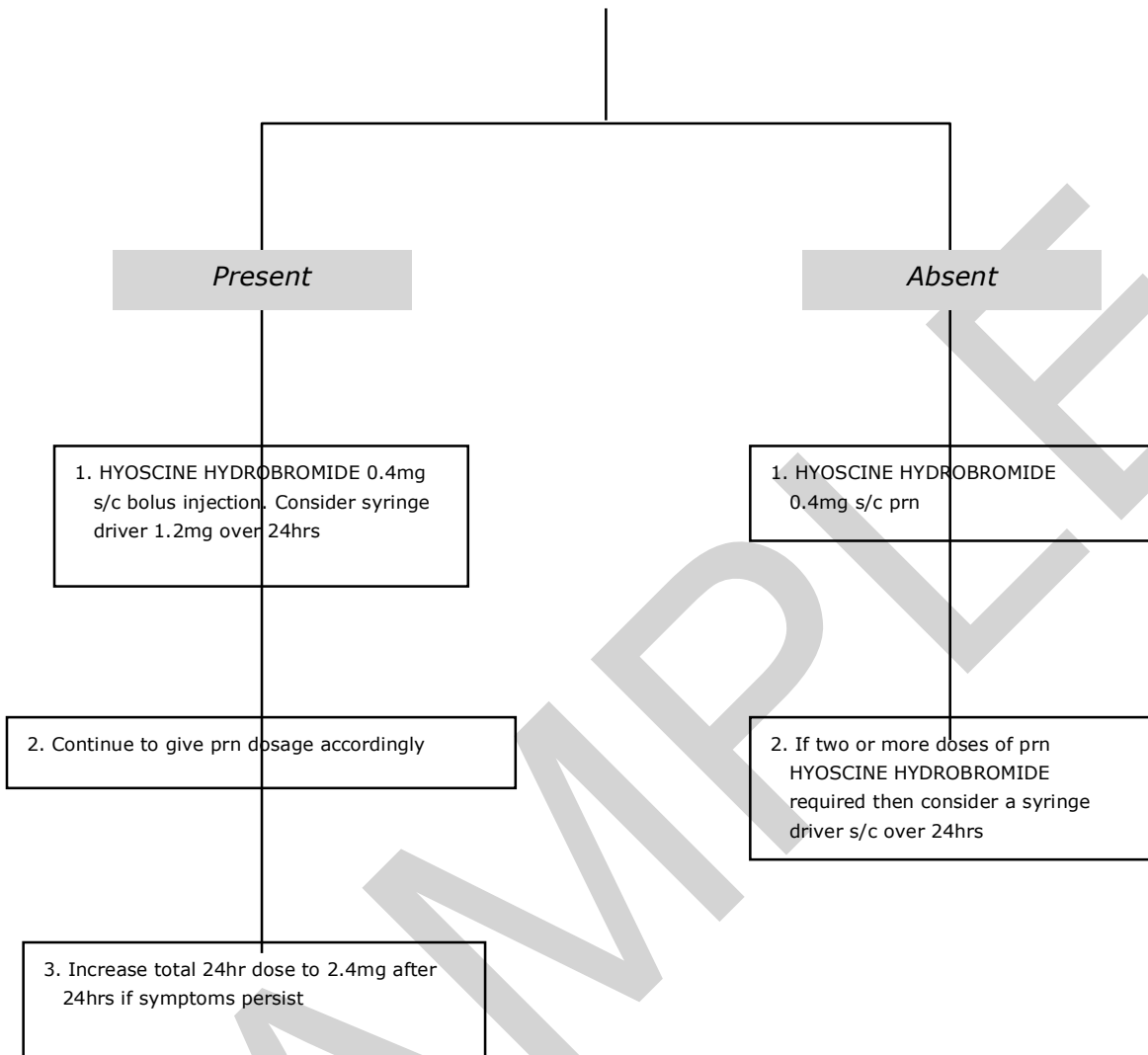


SUPPORTIVE INFORMATION;

- Anticipatory prescribing in this manner will ensure that in the last hours / days of life there is no delay responding to a symptom if it occurs.
- *These guidelines are produced according to local policy & procedure & you may want to alter them for local use and reference them accordingly*



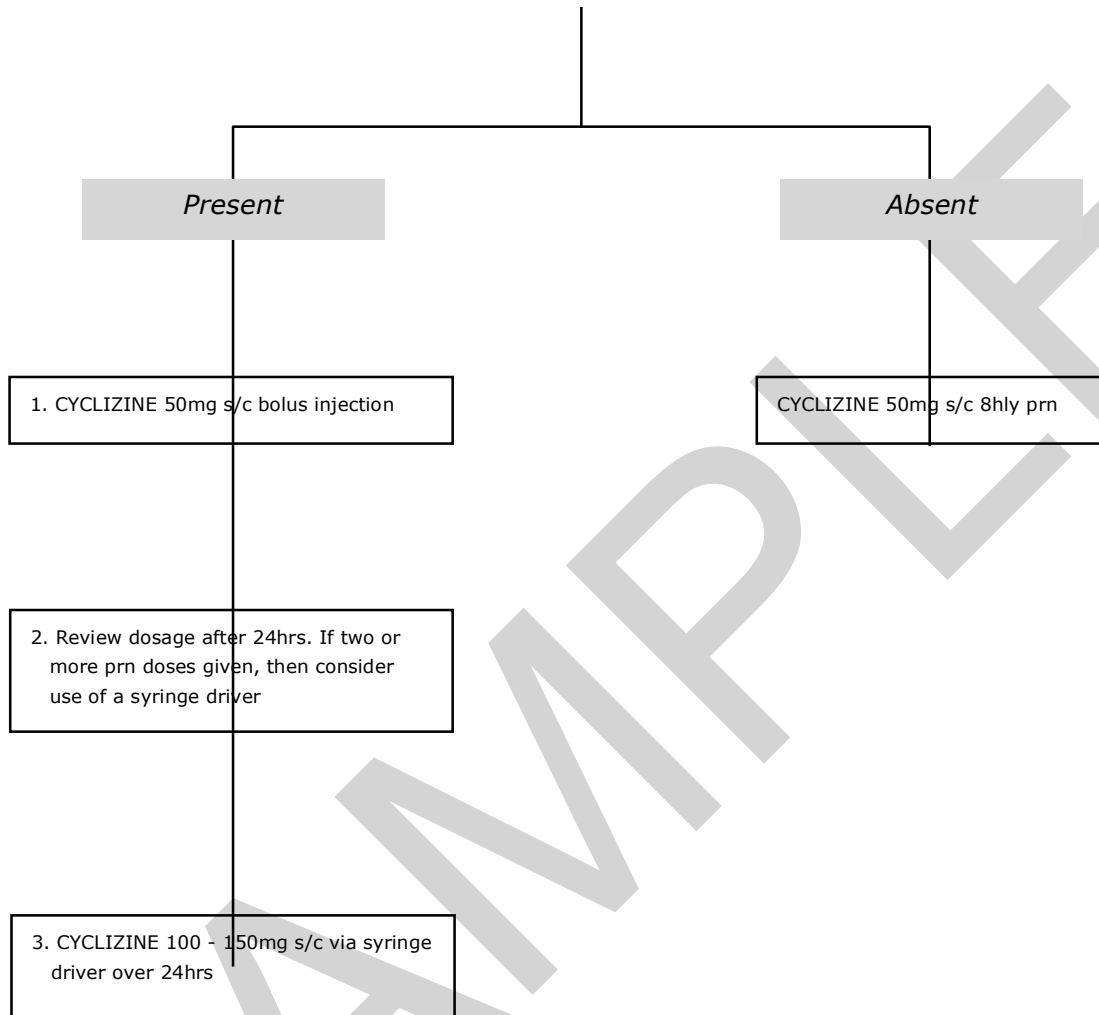
Respiratory tract secretions



SUPPORTIVE INFORMATION:

- Glycopyrronium 0.4mg s/c prn may be used as an alternative
- Anticipatory prescribing in this manner will ensure that in the last hours / days of life there is no delay responding to a symptom if it occurs.
- *These guidelines are produced according to local policy & procedure & you may want to alter them for local use and reference them accordingly*

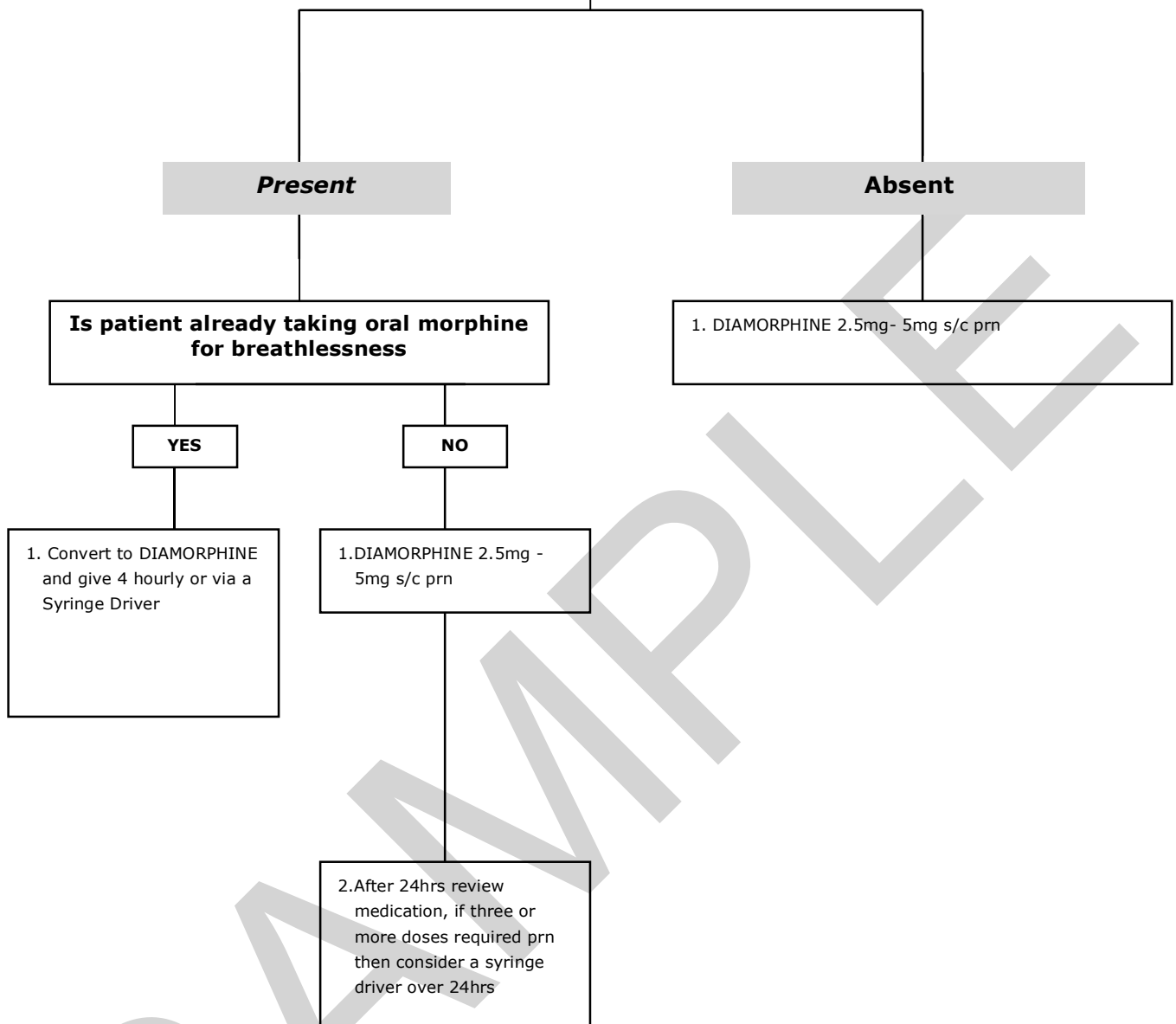
Nausea and vomiting



SUPPORTIVE INFORMATION:

- N.B. Always use water for injection when making up Cyclizine to correct volume.
- Cyclizine is not recommended in patients with heart failure.
Alternative antiemetics according to local policy & procedure may be prescribed
e.g. **Haloperidol s/c 2.5 – 5mg prn (5 – 10mg via a s/c syringe Driver over 24 hrs)**
Levomepromazine s/c 6.25mg prn (6.25 – 12.5 mg via a s/c syringe Driver over 24hrs)
- Anticipatory prescribing in this manner will ensure that in the last hours / days of life there is no delay responding to a symptom if it occurs.
- *These guidelines are produced according to local policy & procedure & you may want to alter them for local use – many areas have complex algorithms as guidance for the management of nausea or vomiting and may be referenced accordingly*

Dyspnoea



SUPPORTIVE INFORMATION:

- If the patient is breathless and anxious consider Midazolam stat 2.5mg s/c prn
- Anticipatory prescribing in this manner will ensure that in the last hours / days of life there is no delay responding to a symptom if it occurs.
- *These guidelines are produced according to local policy & procedure & you may want to alter them for local use and reference accordingly*