NORTH COAST
AREA HEALTH SERVICE
NSW HEALTH

Hospital/Community Health Centre			M.R.N.
Title Family name			
Given names			
DOB	Sex	Consultant	Ward/Unit

Ward/Unit _____

Date ___/___/___

PALLIATIVE CARE INTEGRATED CLINICAL PATHWAY FOR END OF LIFE CARE

The goal of care:

- Consideration for the whole person,
- Maximise quality of life through symptom management,
- Multidisciplinary approach,
- Support for carer and family.

Indications for using clinical pathway:

1. Recognition of dying phase:

   - **Early Stage*:*** bed bound; loss of interest and ability to drink/eat; cognitive changes: either hypoactive or hyperactive delirium or increasing sleepiness, difficult to swallow medication.
   - **Mid Stage*:*** further decline in mental status--obtunded; "death rattle"- pooled, oral secretions that are not cleared due to loss of swallowing reflex; fever is common, decreased urine output.
   - **Late Stage*:*** unconscious, cool extremities, altered respiratory pattern, fever is common; death.
   - **Time Course**: The time to traverse the various stages can be less than 24 hours or up to several days. Once entered, it is difficult to accurately predict the time course.

2. Clarification of management goals by treating team.
3. Not for resuscitation documented.
4. Notify Palliative Care Consultative team when commencing pathway.

Instructions for use:
Pathway should be initiated as soon as the dying phase is recognised

1. **Initial Assessment*:*** should be completed as the patient is entered onto the Pathway. The Nurse completes page 2. The Doctor completes page 3.
2. **Ongoing Assessment:** Page 4 to 6 be completed by the Nurse every shift. **The Doctor will review the patient daily** and document in progress notes.
3. **Variance:** occurs if the Pathway is not followed as expected. Any variance should be recorded. E.g. if it was considered more appropriate to continue with IV fluids this action should be explained as a variance. **N.B. a variance is not wrong but it is important to record to help with audit**.
4. **Multi-disciplinary progress:** Pathway prompts full use of multidisciplinary members of palliative care team.
5. **Consult Palliative Care team to assist with or discuss management (Ext 7675).**
6. **To be placed on chart holder in place of Nursing Care Plan.**

Palliative Care Integrated Clinical Pathway

Ellershaw, J and Wilkinson, S. 2003. Care of the Dying: Liverpool Care Pathway. Oxford University Press

Family name: _____Given name: _____MRN: _____

INITIAL PSYCHOSOCIAL ASSESSMENT

Palliative care integrated clinical pathway

Contact phone numbers:

1. Name:
Relationship to patient:
Phone No:
Mobile phone No:
Contact at any time? ☐Yes ☐No

Contact phone numbers:

2. Name:
Relationship to patient:
Phone No:
Mobile phone No:
Contact at any time? ☐Yes ☐No

Cultural Background: _____

Spiritual:

Religious wishes known ☐Yes ☐No Denomination_____

Wishes _____

Please tick ☑ If "no" is ticked a notation is required on the variance record

Psychosocial:

Discussion with patient re: stage of illness and aims of care plan	☐Yes ☐No
Formal Will completed	☐Yes ☐No
Maintain privacy (single room if available)	☐Yes ☐No

Family/Carers*:*

Discussion with family/carers re: stage of illness and aims of care plan	☐Yes ☐No
Has the patient's choice of location of death been discussed?	☐Yes ☐No
Funeral arrangements considered?	☐Yes ☐No
Family/carers aware of services / facilities available on the ward?	☐Yes ☐No
NOK identified and contact numbers clarified?	☐Yes ☐No
Do family wish to be present at the death?	☐Yes ☐No
GP Notified?	☐Yes ☐No

Referred to:

Social Work	☐Yes ☐No
Chaplain or Clergy	☐Yes ☐No
Supply leaflet "Understanding the Dying Process"	☐Yes ☐No

Patient Registered on Cerner as Palliative Care ☐Yes ☐No

Other issues (list and date)_____
_____
_____
_____
_____

Signature: _____ Designation: _____ Date____/____/___

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INITIAL MEDICAL ASSESSMENT

All patients on the Pathway are to have a regular and prn medication order for the following, as appropriate:

Pain	**Regular ☐**	**plus prn ☐**	**Dyspnoea**	**Regular ☐**	**plus prn ☐**
Agitation	**Regular ☐**	**plus prn ☐**	**Nausea / vomiting**	**Regular ☐**	**plus prn ☐**
Respiratory secretions	**Regular ☐**	**plus prn ☐**			

Please tick ☑

Discontinue inappropriate interventions: (ensure family understand rationale)

☐ Blood tests
☐ Antibiotics
☐ Artificial hydration
☐ Any other investigations
☐ Discontinue inappropriate nursing interventions e.g. vital signs / BGL's

Reassess existing pharmacological management & prescribe as appropriate from the following:

☐ Discontinue non-essential current medication
☐ Appropriate oral medications converted to subcutaneous route
☐ Medications written up for specific symptoms (if present as indicated below)
☐ Medications written up for anticipated symptoms (See prn medications below)

☐ **Pain (monitor response to initial Rx and review at least daily once pain stable)**

If patient already on an oral morphine convert to the appropriate s/c morphine dose. Seek advice on dose equivalency if unsure.
If patient opioid naïve start on 2.5mg. Q4hrs. (or morphine 1mg s/c Q4hrs if frail.)
Chart regular & p.r.n breakthrough dose for all patients.
Reassess analgesia & titrate dose by 25-50%.
Caution in renal failure: use reduced morphine dose or appropriate dose hydromorphone (consult palliative care for dosing information).

☐ **Nausea &/or vomiting**

Metoclopramide 10mg po or s/c tds-qid.
Haloperidol 0.5mg –1mg sc bd - tds.
If bowel obstruction suspected consult palliative care.

☐ **Confusion/Delirium**

Haloperidol 0.5mg po/sc tds
Haloperidol 0.5-1mg s/c Q2hrs prn up to a total dose of 5mg in 24hrs.If not improving consult palliative care team..

☐ **Respiratory Tract Secretions**

Glycopyrrolate 200-400mcg s/c Q2-4hrs prn (if pt conscious)
Hyoscine hydrobromide 400-800mcg s/c q2-4hrs prn (if pt unconscious)

☐ **Diarrhoea**

Exclude faecal impaction.
Imodium PO 2mg q4hrs. (up to 8 tabs/d)

☐ **Hiccups**

Metoclopramide 10-20mg po/sc qid.
Baclofen 5-20mg po qid.

☐ **Restlessness/Agitation** manage reversible causes

Eg pain/ retention /distress/akathisia
In Acute Distress consider midazolam 1-2mg s/c and consult palliative care.
Clonazepam 0.5 mg po tds up to 2mg tds.
Nocte dose 0.5-2mg may be sufficient if patient alert and not distressed in daytime.

☐ **Stomatitis**

Xylocaine viscous used as mouth wash unless sting
Prevent and treat thrush: Nilstat 1mL qid
Treat HSV if patient may gain benefit.
Biotene oral gel topical

☐ **Dyspnoea**

For opioid naïve patient: Morphine 2-5mg po q 4hrs or Morphine 1-5mg s/c q4hrs.
For patient already on morphine (eg for pain) increase regular dose by 25- 50% to cover dyspnoea.
If breathlessness continues or anxiety prominent add Lorazepam 0.5-1mg sublingualbd - qid and prn.

Contact Palliative Care Team for advice or assistance on 6656 7675

Palliative Care References: Palliative Care Therapeutic Guidelines: www.clininfo.health.nsw.gov.au/
RMO handbook **or** www.palliativedrugs.com

Name: _____ Signature: _____ Designation: _____ Date: ___/___/___

Palliative care integrated clinical pathway

Family name: _____Given name: _____MRN: _____

Care Plan

Physical Assessment

Ongoing assessment is to be completed at the end of the shift by nursing staff. If an intervention or outcome is not achieved, it should be documented as a variance.

A multidisciplinary team approach is necessary to provide all the care required at the end of life for the patient, carer and family. Staff should seek the assistance of allied health or the palliative care consultative team. Outcomes listed are considered to be the minimal acceptable standard for end of life care.

Integrated Care Variance code: A – Achieved, V – Variance (If achieved no action needed)

Patient problem / focus	Shift worked	Day 1 Date / /	Day 2 Date / /	Day 3 Date / /	Day 4 Date / /	Day 5 Date / /
Pain **Goal:** *Patient is pain free* -Regular and prn pain medication ordered -Assessment is based on patient's verbal and non-verbal response, including grimacing, groaning on movement.	AM					
	PM					
	ND					
Agitation / Confusion **Goal:** *Patient does not display signs of restlessness* -Exclude urinary retention as possible -? reversible cause -Exclude constipation as possible cause	AM					
	PM					
	ND					
Respiratory Secretions **Goal***: Patient's breathing is not made difficult by noisy, rattly retained secretions* -Repositioning -Glycopyrrolate s.c or Hyoscine s.c prn Gentle suctioning at back of throat.	AM					
	PM					
	ND					
Dyspnoea **Goal:** *Patient is not dyspnoeic* -Fan on face. -Reassuring presence. -Morphine to ↓ anxiety associated with dyspnoea -Lorazepam for anxiety	AM					
	PM					
	ND					
Nurse to sign for each shift	**Shift**	AM PM ND	AM PM ND	AM PM ND	AM PM ND	AM PM ND
	Initials					

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Patient problem / focus	Shift worked	Day 1 Date / /	Day 2 Date / /	Day 3 Date / /	Day 4 Date / /	Day 5 Date / /
Nausea & Vomiting **Goal**: *Patient does not vomit or feel nauseous* -prn medication ordered -? Bowel obstruction – contact palliative care team for management.	AM					
	PM					
	ND					
Skin Care **Goal***: Patient's skin is intact* -Pressure areas are absent -Spenco mattress or other pressure-relieving device. -Regular repositioning	AM					
	PM					
	ND					
Oral Care **Goal***: Patient's mouth is clean and moist* -"Biotene" used if able to swallow. -1-2/hourly using water soaked swab if unconscious. -Lanolin to lips. -Family members educated and encouraged to participate.	AM					
	PM					
	ND					
Eyes **Goal**: *Patient's eyes are moist.* -Regular eye care with saline if unconscious and eyes open.	AM					
	PM					
	ND					
Personal Hygiene **Goal:** *Personal hygiene is Maintained* -Sponge in bed as patient & family require. -Invite carer to participate.	AM					
	PM					
	ND					
Nurse to sign for each shift	**Shift**	AM PM ND	AM PM ND	AM PM ND	AM PM ND	AM PM ND
	Initials					

Palliative care integrated clinical pathway

Family name: _____Given name: _____MRN: _____

Patient problem / focus	Shift worked	Day 1 Date / /	Day 2 Date / /	Day 3 Date / /	Day 4 Date / /	Day 5 Date / /
Elimination **Goal:** *Patient is not constipated* -Oral aperients continued. -3rd daily suppositories are administered to prevent agitation from constipation.	AM					
	PM					
	ND					
Continence is managed -IDC inserted for patient comfort to reduce physical handling. -Incontinence pads are checked and changed regularly.	AM					
	PM					
	ND					
Psychological support **Goal:** *Patient and family involved in decision making and understand that patient is dying* -Support verbalisation and anticipatory grieving. -Encourage caring activities as appropriate / individualised to family situation and culture. -Offer emotional support.	AM					
	PM					
	ND					
Spiritual support -Provide opportunity for expression of beliefs, fears and hopes. -Provide access to religious resources. -Facilitate religious practices.	AM					
	PM					
	ND					
Nurse to sign for each shift	**Shift**	AM PM ND	AM PM ND	AM PM ND	AM PM ND	AM PM ND
	Initials					

Time of death: Date of Death:	/ /	Staff concerns regarding death or bereavement phase _____ _____ _____
Family present: If no, were family notified of death:	☐Yes☐No ☐Yes☐No	Referral to:
GP notified of death: Consultant/s notified: Community Nurse notified:	☐Yes ☐No Dr_____ ☐Yes ☐No Dr_____ ☐Yes ☐No Health Centre_____	

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Ward/Unit _____

Ward/Unit _____
Date ___/___/___

Variance record

Definition of variance Any deviation from the clinical pathway, which may be positive or negative, which identifies processes that influence the effectiveness and efficiency of patient care and treatment.

Directions Outcomes in the pathway are considered to be the minimum acceptable standard for end of life care.
If an expected outcome is not achieved then a variance is recorded.
Enter the Variance code with an explanation as to why the variance occurred from the table below.
Detach this page and place in designated folder at time of death.
Data is collected with a view to outcome.

Variance code.

Patient	P1 – condition	P2 - decision	P3 - other
Health Worker	H1 – decision	H2 - response time	H3 - availability
Family/Carer	F1 – decision	F2 – availability	F3 - other
System	S1 –medication supply / delay		S2 - equipment supply / delay

Diagnosis_____

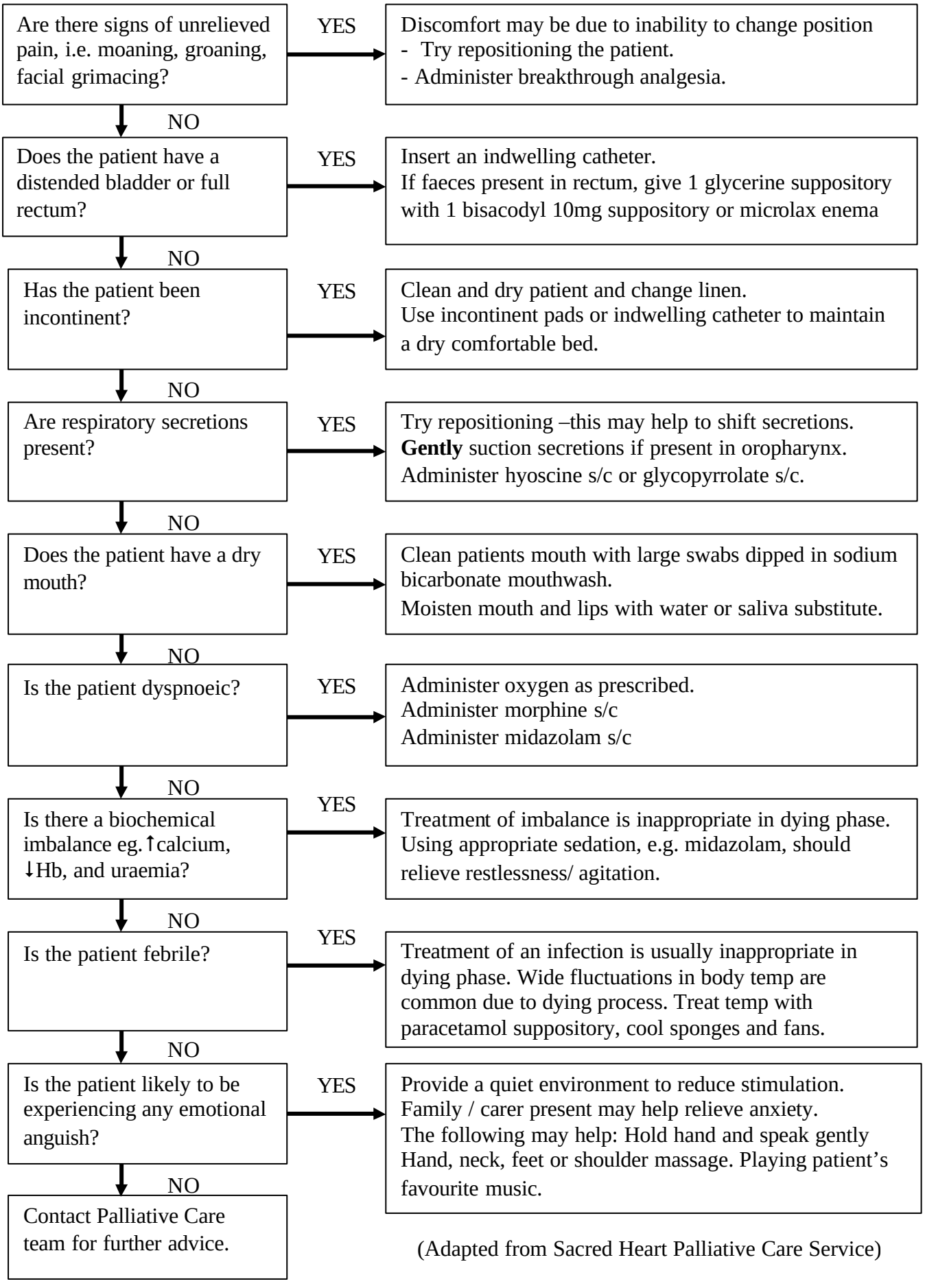
Date	Variance code	Why did variance occur	Action	Outcome

Family name: _____Given name: _____MRN: _____

Date	Variance code	Why did variance occur	Action	Outcome

Palliative care integrated clinical pathway

Palliative Care Restlessness / Agitation Flowchart



(Adapted from Sacred Heart Palliative Care Service)