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End of Life Care Pathway

St George Hospital

Date: ___________ **Ward:** _________

Date of admission: ____________ **Diagnosis:** ____

1. **Inclusion Criteria for patients for End of Life Care Pathway (ELCP)**
   - 1.1 Multidisciplinary team have agreed that the patient is dying
   - 1.2 Not for Resuscitation (NFR) documented

2. **Indicators of terminal phase (two or more must be present)**
   - ☐ Profoundly weak
   - ☐ Essentially bed bound
   - ☐ Semi comatose
   - ☐ Only able to take sips of fluid
   - ☐ No longer able to take tablets

3. **Implementation of ELCP**

   3.1 Notify Palliative Care consultative team if any concerns

   (Mon-Fri: CNC page 502; CNS page 266, 349; Registrar page 997; Palliative Care Medical Consultant on call after hours via switchboard)

   3.2 Medical staff to complete initial medical team assessment sheet

   3.3 Initial psychosocial assessment completed by nursing staff or social work

   3.4 Initial and ongoing physical assessment completed by nursing staff

   3.5 Place completed ELCP in resource folder (spare copies in folder)

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Palliative Care Recommended Medications

Agitation
Check for reversible cause – pain, urinary retention. Midazolam 2.5 – 5mg sci PRN q2-4hrs. If persistent 2.5-5mg sci q4hrs regularly with an identical PRN dose q2-4 hrs.

Anxiety/Confusion
Lorazepam 0.5mg po / sublingual BD – TDS for anxiety **or** Temazepam 10-30mg po nocte **or** Clonazapam 0.5mg – 2mg po - sublingual BD –TDS for anxiety/ myoclonus.

Confusion/Delirium
Identify any reversible cause.
Initially: Haloperidol 1mg BD po/ sci.
Then 1-2mg po/sci q 2-4hrs PRN.
If refractory consult Palliative Care Team

Constipation
Assessment with PR exam may be required if seeking cause for agitation. Consider Glycerine & Durolax suppositories (may not be appropriate to intervene in terminal phase). If able to swallow, consider prophylactic coloxyl & senna 1-3 tabs BD or TDS to prevent constipation.

Diarrhoea
If faecal impaction with overflow excluded, Immodium 2 tabs q4h PRN / regularly.

Dyspnoea
For opioid naive patient: Morphine 2 - 5mg po or 1-5mg sci q4h. *For opioid treated patient:* Increase current dose by 25 -50%. If breathlessness continues, add Lorazepam 0.5mg –1mg sublingually BD-QID and PRN.

Hiccups
Metoclopramide 10 –20mg QID po/sci, Baclofen 5-20mg QID.
If persists contact Palliative Care Team

Fever
Paracetamol 1g q4h po / prn or Dexamethasone 1 mg po / sci q12h.

Pain Management
For opioid naive patient:
Morphine 2.5mg sci q4h with same dose PRN Q2-4hrs. If pain uncontrolled, increase dose (Q4h) by 25 – 50%. For patients already on oral opioids convert to sci q4hrs. * Caution in renal impairment – change Morphine to Hydromorphone. *If pain remains uncontrolled consult Palliative Care Team.*

Pruritis
Diphenhydramine 25 – 50mg po / IMI q12hr, Hydrocortisone 1% Cream to affected areas q6hr. Dexamethasone 1mg po / sci daily, alone or in combination with above.

Respiratory Tract Secretions
Hyoscine hydrobromide 400 – 800mcg q 2-4 hrs sci if patient unconscious, Glycopyrrolate 200 – 400mcg q2 –4 hrs sci (if patient conscious).

Stomatitis/Mucositis/Oral Thrush
For painful oral mucosa -Xylocaine viscus gargle, Orabase gel topically. To treat oral thrush Nystatin drops 2ml q4hr. To clean mouth - Sodium Bicarbonate Mouthwash QID.

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Initial Medical Team Assessment *Medical Officer to complete*

*NB: If you tick **No** to goals 2,3,4,or 5 please provide explanation at the end of section*

Goal 1: Patient symptoms are identified *(tick **Yes** if symptom present and **No** if absent)*

Anxiety / insomnia	**Yes** ☐	**No** ☐	Hiccoughs	**Yes** ☐	**No** ☐
Confusion / agitation	**Yes** ☐	**No** ☐	Nausea / vomiting	**Yes** ☐	**No** ☐
Constipation	**Yes** ☐	**No** ☐	Pain	**Yes** ☐	**No** ☐
Depressed mood	**Yes** ☐	**No** ☐	Pruritis	**Yes** ☐	**No** ☐
Diarrhoea	**Yes** ☐	**No** ☐	Stomatitis	**Yes** ☐	**No** ☐
Dyspnoea	**Yes** ☐	**No** ☐	Respiratory secretions	**Yes** ☐	**No** ☐
Fever	**Yes** ☐	**No** ☐	Dry mouth	**Yes** ☐	**No** ☐
Oral thrush	**Yes** ☐	**No** ☐			

Goal 2: **Non essential medications are discontinued** Yes ☐ No ☐

Goal 3: **Appropriate oral medications are changed to subcutaneous route**

Yes ☐ No ☐

Goal 4: **Medications are charted for specific symptoms:** *(if no, give reason below)*

Pain	**Yes** ☐	**No** ☐	Respiratory secretions	**Yes** ☐	**No** ☐
Nausea / vomiting	**Yes** ☐	**No** ☐	Dyspnoea	**Yes** ☐	**No** ☐
Agitation	**Yes** ☐	**No** ☐			

See recommended medication suggestions for pain management and symptom control

Goal 5: **Inappropriate interventions are discontinued** *(if no, give reasons below)*

Blood tests	**Yes** ☐	**No** ☐	Artificial hydration	**Yes** ☐	**No** ☐
Antibiotics	**Yes** ☐	**No** ☐	Routine observations	**Yes** ☐	**No** ☐

Variance *(if answered No to goals 2,3,4,5 – please provide explanation)*

____

____

____

Name and designation: _______________________ Signature: _________________ Date: ________

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End of Life Care Pathway

Initial Psychosocial Assessment

Initial assessment to be completed within 24 hours of inclusion to ELCP

(*may be completed by any member of the team)*

Goal 6: **Insight into condition assessed**

Recognition of dying by the: a) Patient Yes □ No □ Unconscious □

b) Family Yes □ No □

Has the patient's choice of location of death been discussed?

Yes □ No □ Unconscious □ If Yes, where?…………………...

Goal 7: **Religious/ spiritual needs assessment** Religion: ………………………………..

Has Chaplain referral been made? Yes □ No □

Have religious issues been identified? Yes □ No □

Special needs identified - now, at time of and after death Yes □ No □

Goal 8: **Communication with family/other**

Primary contact: Name: ...……………………………………………………..…
Phone Number: ………………….. Relationship to patient: …………………………

Do family wish to be present at time of death? Yes □ No □

When are family/other to be informed of patient's impending death?

At any time □ Not at night □ Stay overnight □

Has social work referral been made? Yes □ No □

Have the family been made aware of hospital facilities e.g. staying overnight,

access to hospital after hours, phone numbers to ward? Yes □ No □

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End of Life Care Pathway

Initial and Ongoing Physical Assessment *(completed once per shift by nursing staff)*

"A" = achieved "NA" = not achieved *(if not achieved please give brief explanation in box)*

Date:						
Patient Problem/Focus	**AM**	**PM**	**ND**	**AM**	**PM**	**ND**
Pain **Goal 9:** Patient is pain free • Assessment is based on patient's verbal and non verbal response, including grimacing, groaning • Appears peaceful						
Agitation **Goal 10:** Patient does not display signs of restlessness/agitation • Exclude urinary retention or possible reversible cause • Exclude constipation as possible cause						
Respiratory Secretions **Goal 11:** Patient's breathing is not made difficult by noisy, rattly retained secretions • Repositioning • Glycopyrrolate sci or Hyoscine sci regularly to prevent accumulation of secretions • Gently suctioning at back of throat if sounding congested						
Nausea and Vomiting **Goal 12:** Patient does not vomit or feel nauseous • PRN medication • ? bowel obstruction – contact palliative care team for management						
Skin Care **Goal 13:** Patient's skin is intact • Pressure areas are absent • Pressure relieving aids used • Patient is moved for comfort only • Pressure sore wound care reduced to once daily dressings						
Signature						

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End of Life Care Pathway

Initial And Ongoing Physical Assessment *(completed once per shift by nursing staff*

Date:						
Patient Problem/Focus	**AM**	**PM**	**ND**	**AM**	**PM**	**ND**
Oral Care **Goal 14:** Patient's mouth is clean and moist • Artificial saliva • Regular mouth care attended 1-2 hourly using water soaked swabs if unconscious • Lanolin to lips • Family members educated and encouraged to participate						
Eyes **Goal 15:** Patient's eyes are moist • Regular artificial tears drops is unconscious and eyes open						
Personal Hygiene **Goal 16:** Personal hygiene is maintained • Sponge in bed as patient and family require						

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End of Life Care Pathway

Ongoing Psychosocial Assessment

Complete once a shift by nursing or social work staff

Date:						
Patient Problem/Focus	**AM**	**PM**	**ND**	**AM**	**PM**	**ND**
Psychosocial support **Goal 20**: Patient and family are involved in decision making and understand that patient is dying • Inform of measures taken to maintain comfort • Encourage family caring activities as appropriate/individualised to family situation and culture • Facilitate verbal and tactile communication • Assist family with transport/parking, funeral, financial issues						
Spiritual support **Goal 21:** Spiritual support provided • Provide opportunity for expression of belief, fears and hopes • Provide access to religious resources • Facilitate religious practices						
Bereavement Support **Goal 22:** Bereavement support is offered • Bereavement leaflet is given to the family						
Signature						

Date of Death: ....

Family Present: Yes □ No □

Acknowledgements: *Ellershaw, J and the Palliative Care Teams at both the Marie Curie Centre Liverpool and the Royal Liverpool University Hospitals UK (2002), who have pioneered the Liverpool Care Pathway to achieve evidence based high quality standards of care for the dying patient.*
Beth Israel Pathway (PCAD): Marilyn Bookbinder

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