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NHS
Wakefield District

Guidelines for the Community Integrated Care Pathway for the Last Days of Life

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Version Control Sheet

Document Title: Guideline for the Community Integrated Care Pathway for the Last Days of Life

Version: V1

Version	Date	Author	Status	Comment
0.1	January 2005-2006	Janet Millard, Members of the Community Nursing team and The Macmillan Clinical Nurse Specialist	Pilot Study	Three Practices within the East side of the Wakefield District Community Health Services. At the end of the study, data was collected retrospectively by analysing the Integrated Care Pathway for the Dying Patient. Also at this time District nurses notes were collected and data was analysed.
0.2	11 July 2006	Members of the Community Nursing Service	Pilot Study	The District Nurses developed guidelines for the use of the Integrated Care Pathway. Both documents were ratified via the Record Management group. It was agreed for the document to be implemented throughout the East side of Wakefield District Community Health Services. A full education programme was undertaken for all community nursing staff and GP practices. A train the trainer approach was used. Each community nursing team was left with a teaching pack.
0.3	July 2007		Roll out to the West Side of Wakefield District Community Health Services	An End of Life Care Facilitator was appointed to help introduce the Integrated Care Pathway to the West Side of the Wakefield District Community Health Services. Education was given to two practices (Stanley and Outwood). The approach to training was mirrored from the method used in the East.
0.4	June 2009	Members of the Specialist Palliative Care Team.		This is now seen as a quality maker for Palliative Care Services (please see references). Wakefield District Community Health Care Services are now adopting this tool as part of the CQUIN assessment
0.5	June 2009	Members of the Specialist Palliative Care Team.	Draft	Revised draft incorporating comments for consideration by the Community Nursing teams
0.6	October 2009	Members of the Specialist Palliative Care Team and members of the medicine management team	Draft	Revised draft incorporated comments, on the Symptom Control Guidelines.

0.7	October 2009	Members of the Specialist Palliative Care Team	Draft	Symptom Control Guidelines approved by the trust Medicines Management group
0.8	October 2009	Members of the Specialist Palliative Care Team	Draft	Revised draft incorporating comments for consideration by the Policy Group and intranet consultation in preparation for consideration and approval at Quality Forum
V1	October 2009	Members of the Specialist Palliative Care Team	Final version	Approved at Quality Forum

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1 Introduction

The purpose of these guidelines is to assist staff to use the Liverpool Care Pathway for the Dying Patient (LCP) or as it is known locally the Community Integrated Care Pathway for the Last Days of Life (ICP). The ICP is an end of life tool which transfers the hospice model of care into other care settings, providing a multi-professional document which is an evidence based framework for end of life care.

2 Aims and Objectives

NHS End of Life Care Strategy is part of an overall initiative to address inequality of care for dying patients and their families. The NHS has identified by taking realistic goals/solutions and adopting them to the local needs of the population it will assist staff to ensure that the patient receives optimum care.

Nationally there is now evidence that the ICP can provide data that demonstrates the care given to the dying patient and their family. **It forms all or part of the patient's clinical records.** The ICP also has an auditable tool which will enable the Trust to evidence the standard of care given through its quality improvement plans, the aim being to promote a good death for all patients irrespective of their condition.

It is hoped with the appropriate education it will improve patients care, stop unnecessary admissions and help facilitate patients' choice regarding preferred place of death.

These guidelines are intended for any employee of Wakefield District Community Healthcare Services involved in the care of the dying patient and their family. The ICP has been developed in consultation with both national and local initiatives.

3 Scope of the Guideline

The Integrated Care Pathway provides guidelines/evidence of the care required for the dying patient. This includes:

- Comfort measures
- Anticipatory prescribing of medicines and discontinuation of inappropriate interventions
- Psychological and spiritual care
- Family Support
- Care after death

For a patient to be commenced on the ICP there has to be a consensus amongst members of the multi -disciplinary team that the patient:

- Has a known irreversible life threatening illness of any aetiology
- Reversible causes for the patient's current deterioration have been considered and appropriate management given.

- Resuscitation has been discussed by the team and has been deemed inappropriate.

The patient must be actively dying and meet two of the following criteria:-

- Bed bound
- Semi-comatose
- Only able to take sips of fluids
- No longer able to take medication orally

The ICP is divided into three different sections:-

- An initial assessment
- Ongoing care
- Assessment and care after death

The ongoing assessment and care identifies any unmet needs of the patient and family, focusing on meeting comfort measures, symptom management and meeting personal care needs (e.g. mouth cares).

If during the assessment the ICP is diverted in any way this will be identified as a variance. **This is not a failure in care, but an indication for a plan of action individualising the care to the patient's needs.**

The assessment and care after death focuses on the care and support for the carers immediately after death. It identifies the needs of the family and any special request regarding the care of the body.

4 Accountability

The ownership of the ICP is required by Wakefield District Community Healthcare Services. This is imperative for the implementation and sustainability of the ICP.

5 Equality Impact Assessment

Service screen template completed – June 2009.
Full assessment not required.

Wakefield District Primary Care Trust aims to design and implement services, guidelines and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

6 Implementation for Training and Dissemination

All staff implementing the ICP will have access to appropriate information, education, training and guidance in the use of the ICP and common symptoms identified for patients at the end of life. It is hoped this will be achieved through the following education programmes:

It is planned that there will be three education events which will be held throughout the District. The purpose will be to raise knowledge and understanding of death and dying. These training events are being delivered by Specialist Palliative Care Clinical Nurse Specialists and the Consultants in Palliative Medicine.

The identified learning outcomes are that:

- Staff will be able to identify signs and symptoms of death and dying.
- They will be confident to use the Integrated Care Pathway for the Dying Patient.

The education events will be suitable and available to all qualified community nursing staff.

Further smaller education events will be available by using a cascading system of "train the trainer" approach and each community nursing team will be left with a teaching package to assist with this process.

Education can also be obtained through staff accessing the Palliative Care Education Workshops, which are delivered four times per year throughout the Trust. The workshops are split into 5 four sessions aimed at qualified health care professionals who would like to enhance their palliative care skills and knowledge. These education sessions are also mirrored in the Care Home sector.

It is the responsibility of the multi-disciplinary team that they have the appropriate knowledge and skills to identify when a patient is actively dying.

7 Monitoring Compliance with and the Effectiveness of Procedural Documents

For the ICP to become mainstream and sustained it has been identified that the primary education resource will be the Palliative Care Link Nurses, supported by the Practice Educators and by the Specialist Palliative Services. Audit via audit cycle (supported by Professional Leadership and Quality Assurance).

8 References

- PCT, Operational Plan 09/10
- NICE –Improving Supportive and Palliative Care for Adults with Cancer (2004)
- High Quality Care for All NHS Next Stage Review (Lord Darzi 2008)
- The End of Life Care Strategy (2008)
- Delivering Choice Programme (Marie Curie 2008)
- National Audit Office End of Life Care (2008)
- Delivering Healthy Ambitions (2009)

9 Associated Documentation

- Wakefield District, Syringe Driver Policy, Version 01, January (2008)
- Wakefield Continence Practice Guidelines, November (2004)
- Wakefield District Moving and Handling Policy, Version 0.1, June (2008)
- Wakefield District Wound Management Formulary, March (2008)
- Wakefield District Best Practice Policy, Version 0.2, April (2008)
- Wakefield District Waste Management Policy, Version 0.6, October, (2008)
- Safeguarding Adults, Protecting in Practice Policy Procedures, (2008)
- Yorkshire Cancer Network and Humber and Yorkshire Coast Cancer Network Palliative Care Groups, 'A Guide to Symptom Management in Palliative Care', July (2009)
- The Royal Marsden Hospital Manual Clinical Nursing Procedures Seventh Edition (2008) www.rmmonline.co.uk

Appendix 1

NHS
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Community Healthcare Services

COMMUNITY INTEGRATED CARE PATHWAY FOR THE LAST DAYS OF LIFE

Community Nursing Team: ……

GP: ……

Reference:
Care of the Dying, A Pathway to Excellence (2003)
Oxford University Press
Ellershaw, J
Wilkinson, S

NAME: …….. DOB: …….. NHS No: ……..

A Care Pathway is intended as a guide to treatment and an aid to documenting patient progress. Practitioners are free to exercise their own professional and clinical judgement but any alteration to the recommended practice identified within this ICP must be noted as a variance on the sheet at the back of the pathway.
Reference: Changing Gear – Guidelines for Managing the Last Days of Life in Adults. Reviewed and updated November 2006, National Council for Palliative Care.

INSTRUCTIONS FOR USE

1. All goals are in **heavy** typeface. Interventions, which act as prompts to support the goals, are in normal type.

2. If a goal is not achieved (i.e. variance) then record on the variance section on the back page.

3. The Palliative Care Symptom Control Guidelines are printed at the end of the pathway. Please refer to as necessary.

4. If you have any queries regarding the Pathway, please contact the Specialist Palliative Care Team.

CRITERIA FOR ICP
DO NOT INCLUDE A PATIENT IN THIS PATHWAY UNLESS SATISFIED THAT THE FOLLOWING CONDITIONS APPLY

The multi-professional team has agreed that the patient is dying and two of the following apply:-

The patient is bed-bound	❑	Semi-comatose	❑
Only able to take sips of fluids	❑	No longer able to take tablets	❑

Has the patient expressed a preference for the place of death now that it is recognised they are dying?

Yes ❑ No ❑

If yes please state where: Hospital ❑ Hospice ❑ Home ❑

Other: ……

If the preferred place of death cannot be arranged, please provide details as to why:

……

……

……

NAME: …….. DOB: …… NHS No: ……..

ALL CLINICAL STAFF USING THIS CARE PATHWAY PLEASE SIGN BELOW

Name (Print)	Full Signature	Initials	Professional Title	Date

NAME: …….. DOB: …… NHS No: ……

SECTION 1	**PATIENT ASSESSMENT**
DIAGNOSIS	PRIMARY SECONDARY
ALLERGIES	
PHYSICAL CONDITION	Unable to swallow **Yes ❑ No ❑** Aware **Yes ❑ No ❑** Nausea **Yes ❑ No ❑** Conscious **Yes ❑ No ❑** Vomiting **Yes ❑ No ❑** Urinary Tract Symptoms **Yes ❑ No ❑** Constipated **Yes ❑ No ❑** Catheterised **Yes ❑ No ❑** Confused **Yes ❑ No ❑** Respiratory Tract Secretions **Yes ❑ No ❑** Agitation **Yes ❑ No ❑** Dyspnoea **Yes ❑ No ❑** Restless **Yes ❑ No ❑** Pain **Yes ❑ No ❑** Distressed **Yes ❑ No ❑** Other **Yes ❑ No ❑** **(For moving and handling refer to local policy and procedures)**
COMFORT MEASURES	**Goal 1: Current medication assessed and non essential drugs discontinued** Appropriate oral drugs converted to subcutaneous route and syringe driver commenced if appropriate **(refer to local policy and procedures)** **Yes ❑ No ❑**
	Goal 2: PRN subcutaneous medication written up as per Syringe Driver Policy **Yes ❑ No ❑** Pain **Yes ❑ No ❑ N/A ❑** Analgesia **Yes ❑ No ❑ N/A ❑** Nausea & Vomiting **Yes ❑ No ❑ N/A ❑** Anti-emetic **Yes ❑ No ❑ N/A ❑** Agitation **Yes ❑ No ❑ N/A ❑** Sedative **Yes ❑ No ❑ N/A ❑** Respiratory Tract Secretions **Yes ❑ No ❑ N/A ❑** Anticholinergic **Yes ❑ No ❑ N/A ❑** Shortness of Breath **Yes ❑ No ❑ N/A ❑** Opioids/ Benzodiazepines **Yes ❑ No ❑ N/A ❑** Seizures **Yes ❑ No ❑ N/A ❑** Anticonvulsants **Yes ❑ No ❑ N/A ❑**

NAME: …….. DOB: …… NHS No: ……..

	Goal 3: Discontinue inappropriate interventions **Blood Test** **Yes ❑ No ❑ N/A ❑** **Antibiotics** **Yes ❑ No ❑ N/A ❑** **BM Checks** **Yes ❑ No ❑ N/A ❑** Resuscitation discussed and documented with patients and relatives **Yes ❑ No ❑ N/A ❑** **(Please record below and complete appropriate associated documentation)** Deactivate cardiac defibrillators (ICDs) **Yes ❑ No ❑ N/A ❑** Contact patients cardiologist **Yes ❑ No ❑ N/A ❑** Refer to local policy and procedures **Yes ❑ No ❑ N/A ❑** Information leaflet given to patient/carer if appropriate **Yes ❑ No ❑ N/A ❑** **Contact with Out of Hours Services:** **Sent Fax to Out of Hours/appropriate agencies (PLEASE RECORD) Yes ❑ No ❑** Nurse's signature: …… Date: …… Doctor's signature: …….. Date: …… **Goal 3a: Decision to discontinue inappropriate nursing intervention** Routine turning regime (turn for comfort only) **Yes ❑ No ❑** Taking vital signs **Yes ❑ No ❑** **Goal 3b: Syringe driver set up within 4 hours of identified need Yes ❑ No ❑ N/A ❑** Nurse signature …… Date …….. Time ……
If you have charted "No" against any goal so far, please complete variance sheet on the back page	
PSYCHO-LOGICAL/ INSIGHT	**Goal 4: Ability to communicate difficulties assessed e.g. hearing, sight or language** **Yes ❑ No ❑**
	Goal 5: Insight into condition assessed **Comatose** **Yes** **No** **Aware of diagnosis a) Patient** ❑ ❑ ❑ **Recognition of dying b) Patient** ❑ ❑ ❑ **c) Family/Other** ❑ ❑
RELIGIOUS/ SPIRITUAL SUPPORT	**Goal 6: Religious/spiritual needs assessed with patient/carer Yes ❑ No ❑** Formal religion identified: ---------- Special needs now, at time of and after death identified:- (please state) ---------- ---------- ----------

NAME: …….. DOB: …… NHS No: ……

SECTION 1	**Patient assessment Continued**	
COMMUNICATION WITH FAMILY/ OTHERS	**Goal 7: Family/others given information on:-** Not to call emergency ambulance:- Not to attempt to resuscitate :- Contact numbers for 24 hour cover :-	**Yes ❑ No ❑** **Yes ❑ No ❑** **Yes ❑ No ❑** **Yes ❑ No ❑**
COMMUNICATION WITH PRIMARY HEALTH CARE TEAM	**Goal 8: G.P. Practice is aware of patient's condition**	**Yes ❑ No ❑**
SUMMARY	**Goal 9: Plan of care explained and discussed with:-** a) Patient ❑ b) Family ❑ c) Others ❑ d) No ❑	
	Goal 10: **Family/other express understanding of plan of care** Family/carer involvement in physical care	**Yes ❑ No ❑ N/A ❑**

If you have charted "No" against any goal so far, please complete variance sheet on the back page before signing below

Signature of Health Care Professional…….. Title ……

Date …… Time ……

NHS
Wakefield District
Community Healthcare Services

NAME: …… DOB: …… NHS No: ……

AT EACH VISIT REVIEW

Please enter codes in columns A= Achieved V= Variance							
SECTION 2	**PATIENT PROBLEM/FOCUS Record time of visit**	**Date Time**	**Date Time**	**Date Time**	**Date Time**	**Date Time**	**Date Time**
ASSESSMENT PAIN/COMFORT MEASURES							
Pain **Goal: Patient is pain free** • Verbalised by patient if conscious • Pain free on movement • Appears peaceful • Move only for comfort							
Agitation **Goal: Patient is not agitated** • Patient does not display signs of delirium, terminal anguish, restlessness (thrashing, plucking, twitching) • Exclude retention of urine/constipation as cause							
Nausea and vomiting **Goal: Patient does not feel nauseous or vomits** • Patient verbalises if conscious							
Respiratory tract secretions **Goal: Patients breathing is not made difficult by excessive secretions** **Dyspnoea** **Goal**: **Breathlessness is not distressing for patient** • Patient verbalises if conscious • Consider need for positional change **Other symptoms (e.g. wounds)** • (refer to trust to trust policy and procedures)							
TREATMENT/PROCEDURES							
Personal hygiene **Goal: Patient is comfortable** • Check/perform personal hygiene needs as required at each visit • Application of topical preparation.							
Mouth care **Goal: Mouth is moist and clean** • Check each visit							
Micturition difficulties **Goal: Patient is comfortable** • Urinary catheter if in retention • Urinary catheter or pads, if general weakness creates incontinence							
MEDICATION (If not appropriate record as N/A)							
Goal: All medication is given safely and accurately • If medication **not** required please record as N/A • If syringe driver in use, check during each visit (please refer to Syringe Driver Policy)							
Health Care Professional							
If you have charted "V" against any goal so far, please complete variance sheet on the back page							

NAME: …… ….. DOB: ……..…… NHS No: …….

DAILY REVIEW

Please enter codes in columns A= Achieved V= Variance							
SECTION 2	**PATIENT PROBLEM/FOCUS Record time of visit**	**Date Time**	**Date Time**	**Date Time**	**Date Time**	**Date Time**	**Date Time**
MOBILITY/PRESSURE AREA CARE	**Goal: Patient is comfortable and in a safe environment. Clinical assessment of:** • Skin integrity • Need for positional change • Need for special mattress • Personal hygiene • Eye care For moving and handling guidelines refer to local policy and procedures (attach assessment if required)						
BOWEL CARE	**Goal: Patient is not agitated or distressed due to constipation or diarrhoea**						
PSYCHOLOGICAL/ INSIGHT SUPPORT	**Goal: Patient becomes aware of the situation as appropriate** • Patient is informed of procedures • Touch, verbal communication is continued						
CARE OF THE FAMILY/OTHERS	**Goal: Family/Other are prepared for the patient's imminent death with the aim of achieving peace of mind and acceptance** • Check understanding • Recognition of patient dying • Inform of measures taken to maintain patient's comfort • Explain possibility of physical symptoms e.g. agitation/ respiratory tract secretions / pain • Psychological symptoms such as anxiety/depression **Goal: Appropriate religious/spiritual care has been given** • Chaplain/Religious Adviser support offered. • Consider cultural practices.						
Health Care Professional							
If you have charted "V" against any goal so far, please complete variance sheet on the back page							

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Community Healthcare Services

NAME: …….. DOB: …….. NHS No: ……..

VARIANCE ANALYSIS

DATE	WHAT VARIANCE OCCURRED?	WHY DID VARIANCE OCCUR?	ACTION TAKEN	SIGNATURE

NAME: …….. DOB: …….. NHS No: ……..

MULTI-DISCIPLINARY PROGRESS NOTES PLEASE ADD ADDITIONAL INFORMATION HERE			
TIME/DATE	**COMMENT**	**SIGNATURE**	**TITLE**

NAME: …… DOB: …….…… NHS No: ……

VERIFICATION OF DEATH

Date of Death …….. Time of Death……

Persons Present ……..……..…….

Signature of Person verifying death:…….……..…..……

Time: ……

CARE AFTER DEATH

Goal 12: GP Practice contacted re patient's death Date …./.../…		**Yes ❑**	**No ❑**
• Out of Hours		**Yes ❑**	**No ❑**
• District Nurses		**Yes ❑**	**No ❑**
• Palliative Care Team		**Yes ❑**	**No ❑**
• Other health care professionals involved where appropriate		**Yes ❑**	**No ❑**
Goal 13: Collection of equipment e.g. syringe driver/mattress	**N/A ❑**	**Yes ❑**	**No ❑**
• Ensure the family are aware to contact the Undertaker	**N/A ❑**	**Yes ❑**	**No ❑**
• Remove syringe driver	**N/A ❑**	**Yes ❑**	**No ❑**
• Remove catheter (if applicable)	**N/A ❑**	**Yes ❑**	**No ❑**
• Attend to hygiene needs and change clothes if required	**N/A ❑**	**Yes ❑**	**No ❑**
• Replace any dressings to wounds if required	**N/A ❑**	**Yes ❑**	**No ❑**
• Replace dentures if necessary	**N/A ❑**	**Yes ❑**	**No ❑**
Goal 14 : Procedures following death discussed or carried out (If yes, please indicate)		**Yes ❑**	**No ❑**
• Patient had infectious disease		**Yes ❑**	**No ❑**
• Patient had religious/cultural needs		**Yes ❑**	**No ❑**
• Family aware cardiac devices (ICDs) or pacemaker must be removed prior to cremation		**Yes ❑**	**No ❑**
Goal 15: Family/others given information of procedures		**Yes ❑**	**No ❑**
• To contact GP surgery to arrange collection of death certificate		**Yes ❑**	**No ❑**
• To contact local registry office to arrange time to register death		**Yes ❑**	**No ❑**
Goal 16: Bereavement information given		**Yes ❑**	**No ❑**
• Information leaflet on Bereavement and Support given		**Yes ❑**	**No ❑**
• What to do after Death Booklet given (Department of Work & Pensions)		**Yes ❑**	**No ❑**

IF YOU HAVE CHARTED 'NO' AGAINST ANY GOAL SO FAR, PLEASE RECORD VARIANCE ON THE VARIANCE SHEET (PAGE 9)

Health Care Professional …….

APPENDIX 2

SYMPTOM CONTROL GUIDELINES

Contact details for Specialist Palliative Care Teams:-

Pontefract Team:	**01977 781450**
Wakefield Team:	**01924 212290**
The Prince of Wales Hospice:	**01977 708868**
Wakefield Hospice:	**01924 213900**
The Specialist Palliative Care Consultant can be contacted via Mid Yorkshire switchboard:	**0844 8118110**

The use of some of the drugs in these guidelines are outside their product licences but this is identified as best clinical practice within palliative care and is acceptable in this context and can be given subcutaneously.

Non-Medical Prescriber and Medical Staff may prescribe these drugs at their own discretion.

Review date: (to be inserted)

Pain management for patients unable to take oral medication

Is the patient already taking oral morphine?

YES

To convert a patient from oral morphine to a 24 hour syringe driver of diamorphine, **divide the TOTAL dose of oral morphine used in the previous 24 hours by 3**.
e.g. MST 30mg twice daily = 60mg ÷ by 3 = 20mg diarmorphine to be given s/c via a syringe driver infusion over 24 hours.
Remember to add in breakthrough doses of morphine taken within the last 24 hours

PRN Analgesia
Always prescribe s/c prn diamorphine dose which = 1/6 of the dose used in the syringe driver over 24 hours.
Remember at time of commencing syringe driver if patient in pain please give prn dose

If the patient's pain remains uncontrolled, first check that syringe driver is working. Then consider increasing the total dose of analgesia in the syringe driver by **30% over 24 hours.**

If symptoms persist, you are not sure what to do next or are concerned about side effects, please contact the Specialist Palliative Care Team.

NO

ANTICIPATORY PRESCRIBING

- **Ensure diamorphine 2.5mg s/c prn is prescribed and available.**
- **Anticipatory prescribing in this manner will ensure that in the last hours/days of life there is no delay in responding to symptoms if they occur.**

Please review the medication after 24 hours. If two or more doses are required prn then consider a syringe driver over 24 hours

KEY PRACTICE POINTS

Please remember that:

- **Diamorphine is 3 times more potent than oral morphine.**
- **PRN doses of analgesics can be used until symptoms are controlled.**
- **For patients with rapidly escalating pain, please seek specialist advice.**
- **If you are not sure how to convert a patient from other strong opioids to diarmorphine, please contact the Specialist Palliative Care Team.**

Please note that these are only guidelines, each patient should be assessed on an individual basis.

Pain management for patients on a transdermal preparation patch

For a patient on a transdermal preparation patch

Patch Present and pain controlled

Continue with the patch and change as per manufacturer's instructions.

Patch Present but Pain Not controlled

- Give prn injection of diamorphine.
- If pain continues, add diarmorphine to syringe driver in addition to patch using the total of breakthrough used in the last 24 hours as a guideline.

Please do not increase the strength of the patch.

If symptoms persist, and you are not sure what to do next or are concerned about side effects, please contact the Specialist Palliative Care Team.

ANTICIPATORY PRESCRIBING

- **Ensure that diarmorphine is prescribed and available**
- **Anticipatory prescribing in this manner will ensure that in the last hours/days of life there is no delay in responding to symptoms if they occur.**

Please note that the above are for guidance and that each patient should be assessed on an individual basis.

Nausea and vomiting

If the patient is already taking EFFECTIVE anti-emetic orally then prescribe by subcutaneous route

Is the patient nauseated or vomiting at present?

YES

Consider the cause and refer to the Yorkshire Cancer Network symptom control guidelines for treatment

- If cause unknown, refer to Yorkshire Cancer Network symptom control guidelines and give a stat dose of levomepromazine 6.25mg s/c
- Cyclizine 50mg s/c

- Prescribe levomepromazine 6.25mg s/c 6 hourly prn. A total dose of up to 25mg in 24 hours
- Cyclizine 50mg s/c 8 hourly prn. A total of 150mg in 24 hours.

- If levomepromazine is effective consider prescribing 6.25mg – 12.5mg over 24 hours via a syringe driver.
- Cyclizine 100mg – 150mg via syringe driver over 24 hours.
- When using cyclizine please check compatibility with other drugs when mixing in a syringe driver.

NO

ANTICIPATORY PRESCRIBING

- **Ensure levomepromazine 6.25mg s/c 6 hourly prn is prescribed and available**
- **Cyclizine 50mg s/c 8 hourly prn is prescribed and available**
- **Anticipatory prescribing in this manner will ensure that in the last hours/days of life there is no delay in responding to symptoms if they occur.**

Please note that the above are for guidance and that each patient should be assessed on an individual basis. When choosing an appropriate anti-emetic it is important to consider all possible causes.

Respiratory tract secretions

Is the patient at high risk of developing noisy or troublesome respiratory tract secretions?

YES

Consider non-pharmacological measures, e.g.:

- Reposition the patient
- Explain the cause of the problem to the family and emphasise that the patient is unlikely to be aware of the problem

Give a stat dose of hyoscine butylbromide 20mg s/c.

If improvement in symptoms, commence a syringe driver of hyoscine butylbromide 60mg – 120mg s/c over 24 hours.

If symptoms persist and you are not sure what to do next or are concerned about side effects, please contact the Specialist Palliative Care Team.

NO

ANTICIPATORY PRESCRIBING

- **Ensure hyoscine butylbromide 20mg prn is prescribed and available.**
- **Anticipatory prescribing in this manner will ensure that in the last hours/days of life there is no delay in responding to symptoms if they occur.**

If hyoscine butylbromide is needed regularly and has proved effective, commence a syringe driver of 60mg – 120 mg over 24 hours

KEY PRACTICE POINTS

- **Caution – ensure correct product and dose are selected**
- **Hyoscine butylbromide is non-sedative but shorter acting and should be used first line**
- **Hyoscine hydrobromide is both sedative and anti-emetic and may cause agitation**
- **Glycopyrronium (Robinul) may be used as a non-sedative alternative but can be difficult to obtain.**

Please note that the above are for guidance and for patients who are at high risk of developing a death rattle, early intervention maybe beneficial.

Terminal restlessness/agitation

Is the patient restless or agitated at present?

YES

Consider non-pharmacological measures, e.g.:

- Reassurance to family by staff
- Has the patient got a full bladder?
- Promote a calm environment
- Remember restlessness can be transient and intermittent
- Pain
- Breathlessness
- Bowels

If ineffective give midazolam 2.5mg – 5mg s/c prn

If first dose ineffective after 30 minutes repeat the initial dose.

- If second dose ineffective after a further 30 minutes (*total 1 hour*) contact the Specialist Palliative Care Team.

For restlessness recurring within 4 hours commence a syringe driver.

If symptoms persist, you are not what to do next or are concerned about side effects please contact the Specialist Palliative Care Team.

NO

ANTICIPATORY PRESCRIBING

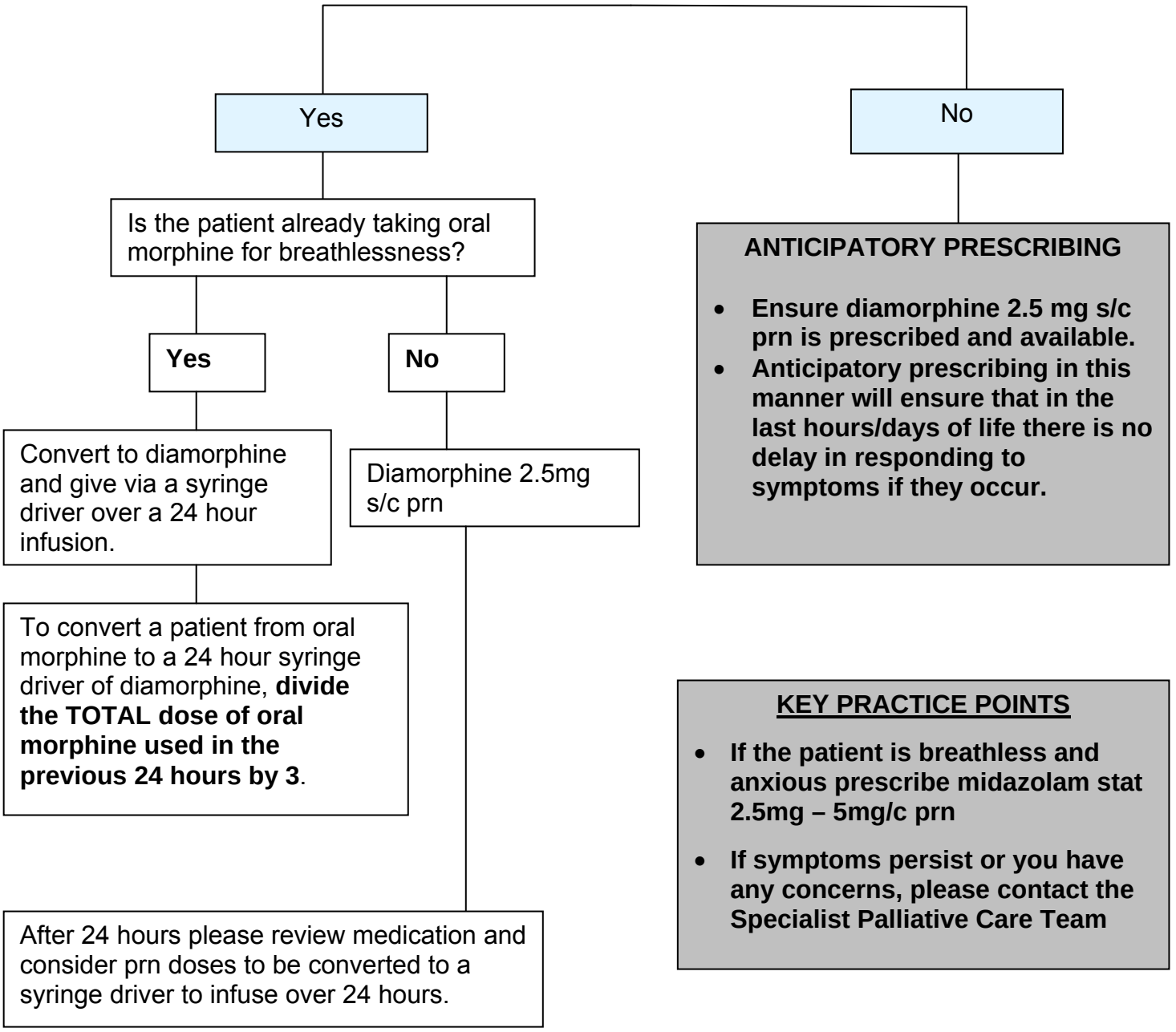
- **Ensure that midazolam 2.5 mg – 5 mg s/c prn is prescribed and available.**
- **Anticipatory prescribing in this manner will ensure that in the last hours/days of life there is no delay in responding to symptoms if they occur.**

KEY PRACTICE POINTS

- **Onset of effect of midazolam s/c is usually 10-20 mins.**
- **Duration of action is 2-3 hours**
- **The usual dosage would be 10-30mg over 24 hours via a syringe driver**
- **Higher doses may be required**

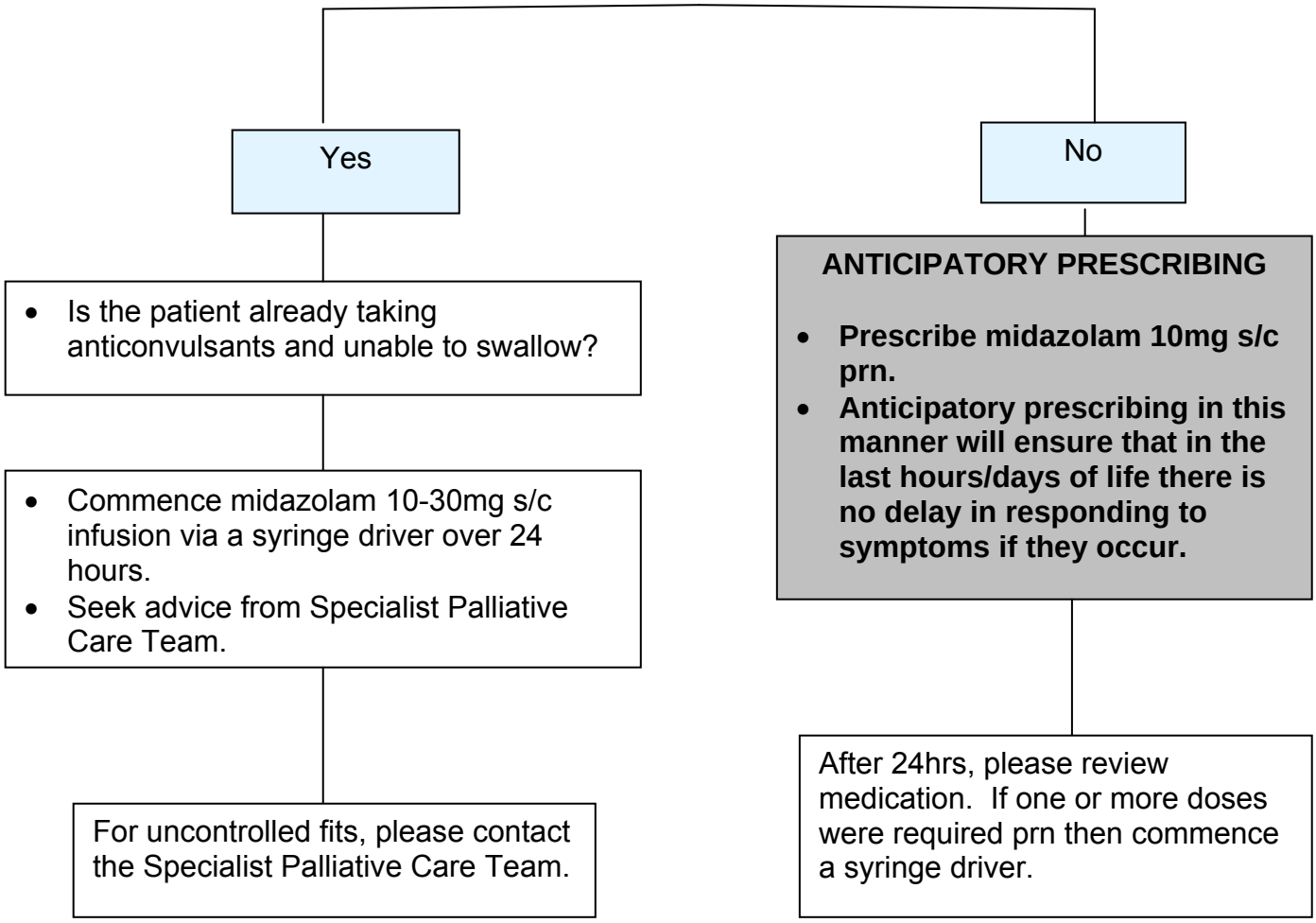
Please note that the above are for guidance and that each patient should be assessed on an individual basis.

Dyspnoea



Please note that the above are for guidance and that each patient should be assessed on an individual basis.

Seizures – risk of fits



Please note that the above are for guidance and that each patient should be assessed on an individual basis.

APPENDIX 3

NHS
Wakefield District
Community Healthcare Services

THE COMMUNITY INTEGRATED CARE PATHWAY
FOR THE LAST DAYS OF LIFE – CLINICAL AUDIT FORM

Has the Preferred Place of Care/Death been documented Yes□ No□ Missing□

Did the person die in preferred place of care Yes□ No□ Missing□

Date ICP commenced ____/____/_____

Time ICP commenced _____am / pm

Date ICP discontinued ____/____/_____

Time ICP discontinued _____am / pm

Date of death ____/____/_____

Time of death _____am / pm

Gender
Male ☐ Female ☐

Primary Diagnosis _____

Secondary Diagnosis _____

Patient age ☐☐☐

Was the front signature sheet filled in correctly and completely?
Yes ☐ No ☐ Partially ☐

Section 1. INITIAL ASSESSMENT	**YES**	**NO**	**N/A**	**Missing**
Physical condition assessed completely				
Goal 1a. Current medication assessed and non essentials discontinued				
Goal 1b. Were oral drugs converted to subcutaneous route and Syringe Driver commenced if appropriate				
Goal 2. PRN subcutaneous medication written up for symptoms as protocol:				
Pain – analgesia				
Nausea and vomiting – anti-emetic				
Agitation – sedative				
RTS – anticholinergic				
Dyspnoea – Anxiolytic/muscle relaxant				
Seizures				
Goal 3. Discontinue inappropriate interventions:				
Blood tests				
Antibiotics				
BM checks				
Not for CPR documentation				
3a. Discontinue inappropriate nursing interventions				
3b. Syringe driver set up within 4 hours of doctors orders				
Section 1. PSYCHOLOGICAL/INSIGHT ISSUES	**YES**	**NO**	**N/A**	**Missing**
Goal 4. Ability to communicate difficulties assessed:				
Patient				
Family				
Goal 5. Insight into condition assessed:				
Awareness of diagnosis - patient				
Awareness of diagnosis – family/other				
Recognition of dying - patient				
Recognition of dying – family/other				
Goal 6. Religious/spiritual support:				
Religious/spiritual needs assessed with - patient				
Religious/spiritual needs assessed with - family/other				
COMMUNICATION WITH FAMILY / OTHERS / PRIMARY HEALTH TEAM	**YES**	**NO**	**N/A**	**Missing**
***Goal 7.** Identified how family/others were to be informed of patients impending death?				
Goal 8. GP practice or locum informed of patients condition				
Goal 9. Plan of care explained to - patient				
Goal 10. Plan of care explained to – family/others				

CARE AFTER DEATH	YES	NO	N/A	Missing
Goal 11. GP or locum informed of patients death				
Goal 12. Collection of equipment				
Goal 13. Procedure following death discussed or carried out				
Goal 14. Family/other given information on procedures				
***Goal 15.** Necessary documentation and advice given to the appropriate person				
Goal 16. Bereavement leaflet given				

SECTION 2:- BREAKDOWN OF OBSERVATIONS
4 hourly assessments (for hospitals and nursing/care homes)
Each Visit (for community and residential homes)
Please enter: - IMPORTANT PLEASE COMPLETE ALL FIELDS
1 – for ACHIEVED
2 – for VARIANCE
3 – for NOT APPLICABLE
0 – for MISSING DATA

	Commence with the recording closest to death					
24 HOURS	**Date/Time**	**Date/Time**	**Date/Time**	**Date/Time**	**Date/Time**	**Date/Time**
SYMPTOM						
Pain						
Agitation						
R.T.S						
Nausea and vomiting						
Dyspnoea						
Other symptoms						
Mouth care						
Micturition						
Medication						

If a variance has been recorded is it clinically acceptable? Yes ☐ No ☐
If a variance has been recorded has it been managed satisfactorily? Yes ☐ No ☐
If not please state the details

_____
_____
_____

SECTION 2 – BREAKDOWN OF OBSERVATIONS

	Commence with the recording closest to death	
12 hourly assessments	**Date/Time**	**Date/Time**
AREA OF CARE		
Mobility		
Bowel Care		
Psych insight (patient)		
Psych insight (family)		
Religious and spiritual support		
Care of the family		

If a variance has been recorded is it clinically acceptable? Yes ☐ No ☐
If a variance has been recorded has it been managed satisfactorily? Yes ☐ No ☐
If not please state the details

_____
_____
_____

SECTION 2 – BREAKDOWN OF OBSERVATIONS
4 hourly assessments (for hospitals and nursing/care homes)
Each Visit (for community and residential homes)
Please enter: - IMPORTANT PLEASE COMPLETE ALL FIELDS
1 – for ACHIEVED
2 – for VARIANCE
3 – for NOT APPLICABLE
0 – for MISSING DATA

24 to 48 HOURS	**Date/Time**	**Date/Time**	**Date/Time**	**Date/Time**	**Date/Time**	**Date/Time**
SYMPTOM						
Pain						
Agitation						
R.T.S						
Nausea and vomiting						
Dyspnoea						
Other symptoms						
Mouth care						
Micturition						
Medication						

If a variance has been recorded is it clinically acceptable? Yes ☐ No ☐
If a variance has been recorded has it been managed satisfactorily? Yes ☐ No ☐
If not please state the details

_____
_____
_____

SECTION 2 – BREAKDOWN OF OBSERVATIONS

12 hourly assessments	**Date/Time**	**Date/Time**
AREA OF CARE		
Mobility		
Bowel Care		
Psych insight (patient)		
Psych insight (family)		
Religious and spiritual support		
Care of the family		

If a variance has been recorded is it clinically acceptable? Yes ☐ No ☐
If a variance has been recorded has it been managed satisfactorily? Yes ☐ No ☐
If not please state the details

_____
_____
_____

SECTION 2 – BREAKDOWN OF OBSERVATIONS
4 hourly assessments (for hospitals and nursing/care homes)
Each Visit (for community and residential homes)
Please enter: - IMPORTANT PLEASE COMPLETE ALL FIELDS
1 – for ACHIEVED
2 – for VARIANCE
3 – for NOT APPLICABLE
0 – for MISSING DATA

48 to 72 HOURS	**Date/Time**	**Date/Time**	**Date/Time**	**Date/Time**	**Date/Time**	**Date/Time**
SYMPTOM						
Pain						
Agitation						
R.T.S						
Nausea and vomiting						
Dyspnoea						
Other symptoms						
Mouth care						
Micturition						
Medication						

If a variance has been recorded is it clinically acceptable? Yes ☐ No ☐
If a variance has been recorded has it been managed satisfactorily? Yes ☐ No ☐
If not please state the details

_____
_____
_____

SECTION 2 – BREAKDOWN OF OBSERVATIONS

12 hourly assessments	**Date/Time**	**Date/Time**
AREA OF CARE		
Mobility		
Bowel Care		
Psych insight (patient)		
Psych insight (family)		
Religious and spiritual support		
Care of the family		

If a variance has been recorded is it clinically acceptable? Yes ☐ No ☐
If a variance has been recorded has it been managed satisfactorily? Yes ☐ No ☐
If not please state the details

_____
_____
_____

APPENDIX 4

Clinical Quality Performance Indicator A
Improving and Sharing Personalised Care Plans

THIS DATA IS REQUIRED BY THE STRATEGIC HEALTH AUTHORITY

	GENERAL DETAILS
1	Date of survey
2	Name of team (both Adult Community Nursing & Community Matron)
3	Name of person completing
4	Base contact number
5	Number of patients on combined ACN & CM caseload on the day of the survey
	LONG TERM CONDITION DETAILS
6	Number of patients on case load with a *Long Term Condition on the day of the survey.
7	Number of patients with a *Long Term Condition with a completed EASYcare assessment held by the patient in a "Your Care File" (Single Assessment Process).
	END OF LIFE PATHWAY DETAILS
8	Number of patients on case load who are on the Integrated Care Pathway (the local version of the Liverpool Care Pathway for the dying patient) on the day of the survey.
9	Number of patients on case load who have a **palliative diagnosis with a completed EASYcare assessment held by the patient in a "Your Care File" (Single Assessment Process).

Definitions

*Long term condition for this purpose is defined as those conditions that cannot, at present, be cured, but can be managed by medication and other therapies. This must be a defined chronic disease such as diabetes, asthma, heart failure, enduring mental health problems and chronic obstructive pulmonary disease (COPD)

**Palliative for this purpose is defined as those people who have a non curable disease and who are potentially in their last year of life. (i.e. any person who is on the Gold Standard Framework Register)

APPENDIX 5

NHS Wakefield District

Screening Process Template - *Equality Impact Assessment.*

1. Name of policy, strategy, project or service:	Integrated Care Pathway for the Dying (Liverpool Care Pathway for the Dying Patient)	
2. What are the main aims and objectives of the policy / strategy or project?	Provide a multi professional document which is evidence based framework for Patients Dying from any condition within the District of Wakefield including patients living in the Care Home Sector which is used in the last 72 hours of life. Provide Education Programmes	
3. Could any groups be negatively affected by this policy/ strategy?	Yes	No X
	Please explain: The document supports service delivery and is available to all groups and can be accessed directly via community services and GP's to support care delivery to patient /family / carer. This document provides the framework to deliver measurable , equitable care to all End of Life patients	
4. Could there be a negative impact under current legislation?	Yes	No X
	Please explain: No group is excluded	
5. Based on the screening process please indicate if this policy should proceed to a full impact assessment or monitoring?	Full impact assessment	Monitoring X
	No current issues Monitoring of implementation is measured via CQUIN and levels of intervention will be reviewed annual as part of the audit cycle.	

Name (Lead Officer): Marian Oakhill Date: May 2009