

Attach ID label here

Inpatient Integrated End of Life Care Pathway

This Care Pathway is intended to be activated when a patient is actively dying and it is agreed that the patient either has or is about to enter the terminal phase or mode of their illness. Assistance with determining the goals of care can be found in the Palliative Care Service Goals of Care guideline.

It is based on the Liverpool Integrated Care Pathway for the Dying Patient (LCP – Hospital). It is intended to be used in any Hospital or Residential Aged Care Facility (RACF) setting and acts as a guide to treatment and an aid to documenting patient progress.

It should be used in conjunction with the Palliative Care Service Terminal Care guideline, and any other relevant symptom guidelines.

Instructions for Use

1. Once commenced, the End of Life Care Pathway becomes the SINGLE RECORD OF ONGOING CARE.
2. All goals are in **heavy** typeface. Interventions, which act as prompts to support the goals, are in normal type. If a goal is not achieved (i.e. a variance), then it is charted in the variance section on the back page.

Medical Staff to complete:

Section 1. Initial Medical Assessment

Section 4. Verification of Death and Care after Death

Record of Variance and Multidisciplinary Progress Notes

Nursing Staff to complete:

Section 2. Initial Nursing Assessment

Section 4. Verification of Death and Care after Death

Record of Variance and Multidisciplinary Progress Notes

3. Ongoing assessment guidelines and prompts are printed on the pages at the end of the pathway. For medication guidelines refer to the palliative care service symptom management guidelines at: http://www.dhhs.tas.gov.au/health_and_wellbeing/palliative_care . Please make reference as necessary.
4. Practitioners are free to exercise their own professional judgement; however, any alteration to the practice identified within this pathway must be noted as a variance.
5. **If the patient has been on the End of Life Care Pathway for more than 72 hrs and death is not imminent, review of the goals of care may be required.**
6. If you have any problems regarding the Pathway contact the Palliative Care Service.

Criteria for commencement of the End of Life Care Pathway

There is agreement that the patient is dying, and two or more of the following apply:

- | | |
|---|---|
| <input type="checkbox"/> Patient is bed-bound | <input type="checkbox"/> Severely limited attention span or semi-comatose |
| <input type="checkbox"/> Only able to take sips of fluids | <input type="checkbox"/> No longer able to take tablets |
| <input type="checkbox"/> Not for Resuscitation (NFR) order or
Limitation of Medical Treatment Order (LMTO)
has been documented | |

Name (Print): _____ Signature: _____ Date: _____

Date Commenced: _____ Time: _____

Affix ID label here

Section 1 INITIAL ASSESSMENT - MEDICAL

Diagnosis: _____

Other relevant conditions: _____

Physical Condition

Unable to swallow	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dyspnoea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Aware	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Conscious	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nausea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Confused	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Restless	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bowel problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Agitated	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Incontinent urine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Twitching	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Catheterised	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Respiratory Secretions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Distressed	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Other: Specify: _____

Comfort Measures

Goal 1: Current medication reviewed and non essentials discontinued.

Inappropriate medication discontinued	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Appropriate oral drugs converted to alternative route	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Goal 2: PRN medication written up for list below as per palliative care service guidelines.

Agitation	Sedative	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pain	Analgesic	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Respiratory Tract Secretions	Anticholinergic	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nausea & Vomiting	Antiemetic	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dyspnoea	Anxiolytic / Opioid	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Goal 3: Inappropriate medical interventions discontinued.

Blood Tests	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Antibiotics	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
IV fluids or medications	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Cardiac defibrillator deactivated	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

Communication

Goal 4: Plan of care explained to, discussed, & understood by:

- Aware that planned care is now focused on care of the dying.
- Patient's and family's concerns identified & documented.
- Advance Care directives addressed.

Patient Yes No

Family / other Yes No

Goal 5: G.P. is aware of patient's condition.

G.P. to be contacted if unaware patient is dying Yes No

If you have charted "No" against any of goals 1-5 please complete variance sheet as attached.

Doctor's Name (Print): _____ Signature: _____ Date: _____

Date commenced: _____ Time: _____

Affix ID label here

Section 2 INITIAL ASSESSMENT - NURSING

Comfort Measures

Goal 6: Inappropriate nursing interventions discontinued & comfort measures implemented.

- Routine turning discontinued – reposition for comfort only Yes No
- Patient nursed on pressure relieving mattress Yes No
- Measurement of vital signs / routine observations discontinued Yes No
- Inappropriate charting discontinued i.e. fluid balance / blood sugar Yes No
- Single room provided if available Yes No

Psychological / Insight

Goal 7: Insight into condition assessed.

- Recognition of dying a) Patient Yes No
- Recognition of dying b) Family / other Yes No

Psychosocial Support

Goal 8: Spiritual / religious / cultural/ emotional needs assessed and addressed.

- Ability to communicate in English assessed as adequate Yes No
- Support of Chaplaincy Team offered Yes No

Religion if specified: _____

In-house chaplaincy support can be contacted via switch board. External chaplaincy / other support:

Name _____ Contact No _____

- Social Work Referral offered (if appropriate) Yes No
- Special needs now, at time of & after death identified and documented in multidisciplinary progress notes attached Yes No

Communication with Family / Other

- Goal 9: Identification of how family/others are to be informed of impending death. Yes No

Primary Contact: _____ Relationship to Patient: _____

Telephone: _____ Mobile: _____

Contact: Anytime Not at night

Residential Aged Care Facility notified of patient's condition Yes No N/A

Communication with Family/ Other

Goal 10: Family / other given information on Hospital or RACF facilities & routines.

Family made aware of car parking, phones, toilet facilities,
and kiosk & cafeteria operating times if available. Yes No

Family given contact phone number Yes No

Family invited to stay overnight Yes No

If you have charted "No" against any of goals 6-10 please complete variance sheet as attached.

Nurse's Name (Print): _____ Signature: _____ Date: _____

Section 3 ONGOING ASSESSMENT

Affix ID label here

Date: _____

NOTE: If the patient has been on the End of Life Care Pathway for more than 72 hours and death is not imminent; review of the goals of care may be required.

Codes (Enter in Columns) A = Achieved V = Variance (not a signature) Refer to Ongoing Assessment Guidelines at the end of the Pathway as required							
SYMPTOM ASSESSMENT	GOAL	0400	0800	1200	1600	2000	2400
Agitation	Patient does not display signs of restlessness or agitation.						
Pain	Patient is pain free						
Respiratory Secretions	Patient's breathing is not distressing due to retained secretions						
Dyspnoea	Patient is not distressed due to breathlessness						
Nausea & Vomiting	Patient does not vomit or feel nauseated						
Other Symptoms							
Specify: _____ Specify: _____							
COMFORT MEASURES	GOAL	0400	0800	1200	1600	2000	2400
Mouth Care	Mouth is clean & moist						
Eye Care	Eyes are clean & not dry						
Micturition	Patient is dry & comfortable						
Skin Care	Skin is clean and patient is comfortable						
Bowel Care	Patient is not agitated or distressed due to constipation or diarrhoea						
Medication	All medication is given safely and accurately						
PSYCHOSOCIAL ASSESSMENT	GOAL	0400	0800	1200	1600	2000	2400
Communication	Verbal / nonverbal communication is continued						
Psychological Support	Patient / family are supported, are involved in decision making & understand patient is dying						
Cultural / Religious / Spiritual Support	Cultural, religious, spiritual needs are identified and rituals are facilitated						
Nurse's signature:							
Repeat this page 24 hourly. If "V" is charted against any goal please complete variance sheet as attached.							

Section 4 VERIFICATION OF DEATH AND CARE AFTER DEATH

Affix ID label here

Date & Time of Death: _____

Persons Present:

Notes:

Nurse's Name (print): _____ Signature: _____

Medical Verification of Death:

Date & Time: _____

Doctor's Name (print): _____ Signature: _____

Care after Death

Goal 11: Obligatory contacts informed of patient's death

Primary contact (if not present at time of death)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Consultant Date _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
GP Date _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Palliative Care Team Date _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
RACF Date _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

Goal 12: Procedures for laying out carried out according to Hospital or RACF policy

Care of the Deceased Patient	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Specific religious/ spiritual / cultural requests attended to	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

Goal 13: Additional procedures following death attended to

Infections disease notification	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Post-mortem discussed	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

Coroner notification Yes No N/A

Goal 14: Hospital or RACF policy followed for patient's valuables & belongings Yes No

Goal 15: Bereavement support information pack provided Yes No

If you have charted "No" against any of goals 11-15 please complete variance sheet as attached.

Nurse's Name (Print): _____ Signature: _____ Date: _____

SECTION 7 ONGOING ASSESSMENT GUIDELINES

SYMPTOM	GOAL	PROMPTS
Agitation	Patient does not display signs of restlessness / agitation	<ul style="list-style-type: none"> * Consider urinary retention as a possible reversible cause * Sedative if necessary as ordered
Pain	Patient is pain free	<ul style="list-style-type: none"> * Assessment based on patient's verbal & nonverbal cues * Patient appears peaceful * Analgesia if necessary as ordered * Report uncontrolled pain for adjustment of analgesia dosage
Respiratory Secretions	Patient's breathing is not distressing due to retained secretions	<ul style="list-style-type: none"> * Reposition * Explain aetiology to family * Gentle suction of oral cavity only if necessary & not distressing for / or resisted by patient * Anticholinergic agent if indicated * Mouth care
Dyspnoea	Patient is not distressed due to breathlessness	<ul style="list-style-type: none"> * Fan to increase airflow * Medications as ordered or as per Guidelines * Positioning to enhance breathing * Reassuring presence * Oxygen if necessary for comfort (rarely indicated)
Nausea & Vomiting	Patient does not feel nauseated or vomits	<ul style="list-style-type: none"> * Patient verbalises if conscious * Anti-emetic as ordered * Mouth care
COMFORT MEASURES	GOAL	PROMPTS
Mouth Care	Mouth is clean & moist	<ul style="list-style-type: none"> * Regular mouth care * Lubricant to lips * Family educated & encouraged to participate
Eye Care	Eyes are clean & moist	<ul style="list-style-type: none"> * Artificial tears / lubricating ointment if eyes open and patient unconscious
Micturition	Patient is dry & comfortable	<ul style="list-style-type: none"> * Pads checked & changed regularly * Urinary retention considered as a cause of distress * In / out catheter insertion if retention causing discomfort
Skin Care	Patient is comfortable in a safe environment, and interventions are minimised	<ul style="list-style-type: none"> * Personal hygiene is maintained * Sponge in bed if needed, as patient / family desire * Pressure relieving aids used * Reposition for comfort only * Pressure area / wound care dressings reinforced if leaking, changed only if offensive * Leaking oedematous limbs - use incontinence pads
Bowel Care	Patient is not agitated / distressed due to constipation or diarrhoea	<ul style="list-style-type: none"> * Pads checked & changed as necessary * Suppositories only if needed for comfort

PSYCHOSOCIAL ISSUES	GOALS	PROMPTS
Communication	Verbal / Nonverbal communication is continued	<ul style="list-style-type: none"> * Encourage verbal & tactile communication * Patient and family are informed of any procedures * Volunteer to sit with patient if needed
Psychological Support	Patient / family are supported, are involved in decision making & understand patient is dying	<ul style="list-style-type: none"> * Ensure family informed & involved * Facilitate participation in patient care if desired * Address concerns with explanation and reassurance * Be aware of possible anxiety, depression or fatigue
Cultural / Religious / Spiritual Support	Cultural, religious, spiritual needs are identified, rituals are facilitated	<ul style="list-style-type: none"> * Provide opportunity for expression of beliefs, hopes & fears * Facilitate access to cultural / religious / spiritual resources