INTEGRATED CARE PATHWAY FOR THE DYING PATIENT

PATIENT'S NAME……UNIT NUMBER…… DATE……..

DATE OF BIRTH……DATE OF IN PATIENT ADMISSION……

DIAGNOSIS: PRIMARY……

SECONDARY……..

A Care Pathway is intended as a guide to treatment and an aid to documenting patient progress. Of course, practitioners are free to exercise their own professional judgement, however any alteration to the practice identified within this ICP must be noted as a variance on the sheet at the back of the pathway.

CONSULTANT: **NAMED NURSE:** **HOSPITAL:**
G.P.: **WARD:**

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 chart on the variance section on the back page
3. The Palliative Care guidelines are printed on the pages at the end of the pathway. Please make reference as necessary.
4. If you have any problems regarding the Pathway contact the Palliative Care Team.

ALL PERSONNEL COMPLETING THE CARE PATHWAY PLEASE SIGN BELOW

Name (Print)	Full Signature	Initials	Professional Title	Date

CRITERIA FOR ICP – DO NOT PUT ON THE PATHWAY UNLESS:

The multi-professional team have agreed the patient is dying ❑
Intervention for correctable cause has been considered and is not possible/appropriate ❑
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	❑

Once it has been decided to place a patient on the pathway please inform DDoc by "Special Message"
DDoc Special Message sent: ❑ *(Standard form on next page)*

References:
1. Ellershaw *et al.* (1997) Developing an integrated care pathway for the dying patient. *Eur.J Pall Care.* **4** (6): 203-207.
2. Ellershaw *et al.* (1999) Can hospice based care be transferred into a hospital setting using the Liverpool Care Pathway for the dying patient? Sixth Congress EAPC, Geneva.
3. Changing Gear – Guidelines for Managing the Last Days of Life in Adults. National Council for Hospice and Specialist Palliative Care Services. (1997) Northamptonshire: Land & Unwin (Data Sciences) Ltd.

This care pathway is based on the Liverpool Integrated Care Pathway for the Dying Patient NHS Beacon project and the North Cumbria Palliative Care Service

Special Message
Dorset Doctors on call.

Patients Name:
Date of Birth:

Home phone number:
Ward phone number:

Diagnosis:

This patient's death is expected within the next few days and the team who usually look after him or her have decided to place him or her on the Last Days of Life pathway.

It has been agreed that this patient should receive symptomatic care only and transfer or admission should only be considered in the most exceptional circumstances. Resuscitation would also be inappropriate.

The patient (where appropriate) and family are fully aware of this decision.* ❑

he/she has been written up for parenteral opiate analgesia, anti-emetic, drugs for restlessness and agitation, and medication for excessive secretions.* ❑

In the case of death the ward nurses would be able to verify the need death without for a doctor to visit.* ❑

*As this message may be passed to a doctor by phone please delete any part not applicable

Date of completion of message……...

Name of person completing message. ……

Fax to DDoc 01202 875319

Date & time faxed:……..

INTEGRATED CARE PATHWAY FOR THE DYING PATIENT

PATIENT NAME: ……. UNIT NO: …….. DATE: ……..

SECTION 1: INITIAL PATIENT ASSESSMENT				
PHYSICAL CONDITION (to be completed by doctor or nurse)	Conscious	**Yes ❑ No ❑**	Urinary problems	**Yes ❑ No ❑**
	Able to swallow	**Yes ❑ No ❑**	Catheterised	**Yes ❑ No ❑**
	Able to speak	**Yes ❑ No ❑**	Agitation	**Yes ❑ No ❑**
	Distress	**Yes ❑ No ❑**	Restlessness	**Yes ❑ No ❑**
	Pain	**Yes ❑ No ❑**	Confusion	**Yes ❑ No ❑**
	Nausea	**Yes ❑ No ❑**	Respiratory tract secretions	**Yes ❑ No ❑**
	Vomiting	**Yes ❑ No ❑**	Dyspnoea	**Yes ❑ No ❑**
	Constipation	**Yes ❑ No ❑**	Other ……..	**Yes ❑ No ❑**

GOALS **(If you chart 'No' against any of the goals below, please complete variance sheet on the back page before signing - thank you)**	
COMFORT MEASURES (to be completed by doctor)	**Goal 1: Current medication assessed and non essentials discontinued** **Yes ❑ No ❑** • Appropriate oral drugs converted to subcutaneous route and syringe driver commenced if appropriate • Inappropriate medication discontinued
	Goal 2: PRN subcutaneous medication written up for list below as per Protocol Yes ❑ No ❑ (see blue sheets at back of ICP for guidance) • Pain ☐ ☐ ☐ Analgesia • Nausea and vomiting ☐ ☐ Anti-emetic • Agitation ☐ ☐ ☐ Sedative • Respiratory tract secretions ☐ Anticholinergic
	Goal 3: Discontinue inappropriate interventions **Yes ❑ No ❑** • Blood Tests • Antibiotics • I.V.s (fluids/medications) • Discuss use of interventions for comfort only (e.g. document CPR status)
	DOCTOR'S SIGNATURE …… DATE……
COMFORT MEASURES (to be completed by nurse)	**Goal 3a: Decisions to discontinue inappropriate nursing interventions taken** **Yes ❑ No ❑** • Routine Turning Regime (turn for comfort only) • Taking vital signs
	Goal 3b: Syringe driver set up within 4 hours of identified need **Yes ❑ No ❑ N/A ❑**
	NURSE'S SIGNATURE …… DATE …….. TIME……

IF YOU HAVE CHARTED "NO" AGAINST ANY GOALS SO FAR, PLEASE COMPLETE VARIANCE SHEET ON THE BACK PAGE BEFORE SIGNING ABOVE –THANK YOU

SECTION 1 :	**INITIAL PATIENT ASSESSMENT (*continued*)**
PSYCHOLOGICAL/ INSIGHT	**Goal 4: Ability to communicate in English assessed as adequate** **Yes ❑ No ❑** See List of Translators – ********) (
	Goal 5: Insight into condition assessed — **Unconscious** — **Yes** — **No** Aware of diagnosis — a) Patient — ❑ — ❑ — ❑ b) Family/Other — ❑ — ❑ Recognition of dying — c) Patient — ❑ — ❑ — ❑ d) Family/Other — ❑ — ❑
RELIGIOUS/ SPIRITUAL SUPPORT	**Goal 6: Religious/spiritual needs assessed with patient/carer** **Yes ❑ No ❑** Formal religion identified: …… ***Support:*** Church of England ****** ☏ **** Roman Catholic Priory, ****** ☏ **** Methodist minister, ****** ☏ ***** *Other religious/spiritual support:* (please complete as needed) Name: …… ☏ …… *Special needs now, at time of & after death identified:* (please complete as needed) ……
COMMUNICATION WITH FAMILY/OTHER	**Goal 7: Identify how family/other are to be informed of patient's impending death** **Yes ❑ No ❑** At any time ❑ Not at night-time ❑ Stay overnight at Hospital ❑ Primary Contact Name …… Relationship to patient …… Tel no: …… Secondary contact ……Tel no: ……
	Goal 8: Family/other given hospital information on:- **Yes ❑ No ❑** Car parking; accommodation; availability of refreshments/food; visiting policy; payphones; washrooms & toilet facilities. Any other relevant information
COMMUNICATION WITH PRIMARY HEALTH CARE TEAM	**Goal 9: G.P. Practice is aware of patient's condition** **Yes ❑ No ❑** G.P. Practice to be contacted if unaware patient is dying
SUMMARY	**Goal 10: Plan of care explained & discussed with:-** a) Patient ❑ b) Family ❑ c) Other ❑ **Yes ❑ No ❑**
	Goal 11:Family/other express understanding of care plan **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 – THANK YOU

Signature: Health Care Professional…… Title…… Date…….

INTEGRATED CARE PATHWAY FOR THE DYING PATIENT

PATIENT NAME: ……. UNIT NO: ……. DATE: ……..

SECTION 2 : PATIENT CARE *Enter code in columns: A…Achieved V…Variance*					**Please complete every 4 hours.** **(Only one A or V needed per box)**	
FOUR HOURLY PERIOD ENDING: .	**08:00**	**12:00**	**16:00**	**20:00**	**24:00**	**04:00**
ASSESSMENT OF PAIN AND OTHER SYMPTOMS						
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 as cause						
Respiratory Tract Secretions **Goal: Patients breathing is not made difficult by excessive secretions**						
Nausea & Vomiting **Goal: Patient does not feel nauseous or vomits** • Patient verbalises if conscious						
Other symptoms (e.g. dyspnoea) a) …… b) …… c) ……						
TREATMENT/PROCEDURES						
Mouth Care **Goal: Mouth is moist and clean.** • As per local Mouth Care Policy • Mouth care to be given at least 4 hourly						
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 & accurately. • If syringe driver in progress check at least 4 hourly • If medication not required please record as N/A						
Nurse's Signature:	Early		Late		Night	

Please repeat this page each 24 hrs. Spare copies are on ward

IF YOU HAVE CHARTED "V" AGAINST ANY GOAL SO FAR, PLEASE COMPLETE VARIANCE SHEET ON THE BACK PAGE BEFORE SIGNING ABOVE – THANK YOU

PATIENT NAME: ……. UNIT NO: ……. DATE: ……..

SECTION 2 : PATIENT CARE (*continued*) *Please complete 12 hourly. Enter code in columns: A…Achieved V…Variance*			
MOBILITY/PRESSURE AREA CARE	**Goal: Patient is comfortable and in a safe environment** Patient is moved for comfort only with pressure relieving aids as appropriate e.g. special mattress		
BOWEL CARE	**Goal: Patient is not agitated or distressed due to constipation or diarrhoea**		
PSYCHOLOGICAL/ INSIGHT SUPPORT	**Patient** **Goal: Patient becomes aware of the situation as appropriate** • Patient is informed of procedures • Touch, verbal communication is continued		
	Family/Other **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 fatigue • Explain food and drink are no longer vital • Psychological symptoms such as anxiety/depression • Social issues such as financial implications		
RELIGIOUS/SPIRITUAL SUPPORT	**Goal: Appropriate religious/spiritual support has been given** Notes:		
CARE OF THE FAMILY/OTHERS	**Goal: The needs of those attending the patient are accommodated** Notes:		

Please repeat this page each 24 hrs. Spare copies are on ward

IF YOU HAVE CHARTED 'V' AGAINST ANY GOAL SO FAR, PLEASE COMPLETE VARIANCE SHEET AT THE BACK OF THE PATHWAY BEFORE SIGNING BELOW – THANK YOU

Nurse's signature:	Early	Late	Night

PATIENT'S NAME………………UNIT NUMBER……………DATE………..

MULTIDISCIPLINARY PROGRESS NOTES (Please sign and date each entry)

PATIENT NAME: ……. UNIT NO: ……. DATE: ……..

SECTION 3: AFTER DEATH

VERIFICATION OF DEATH

Date of Death …… Time of Death ……

Persons Present ……

Notes ……

……

Signature of Nurse/Doctor…… Time Verified ……

CARE AFTER DEATH CHECKLIST

Goal 12: GP Practice contacted re patient's death Date: __/__/__ Yes ❑ No ❑

Goal 13: Procedures for laying out followed according to hospital policy Yes ❑ No ❑

Goal 14: Procedure following death discussed or carried out N/A ❑ Yes ❑ No ❑
(If yes please indicate)

Patient had infectious disease ❑
Patient has religious needs ❑
Post mortem discussed ❑
Input patient's death on hospital computer ❑

Goal 15: Family/other given information about legal formalities after death Yes ❑ No ❑

- Death certificate issued
- Family/other informed of where and when to collect death certificate
- Family/other aware of how to register death

Goal 16: Hospital policy followed for patient's valuables & belongings Yes ❑ No ❑

Belongings listed and put in patient's property bag

- Valuables listed and put in sealed envelope in designated locked ward cupboard

Goal 17: Family/other given necessary documentation and advice Yes ❑ No ❑

- DSS information booklet and Help the Aged booklet
- Accompanying local information leaflets

Goal 18: Bereavement support Yes ❑ No ❑

- Discussed, ensure family are aware of Help the Aged bereavement booklet and local information leaflet

Nurse's Signature: …… Date ……

IF YOU HAVE CHARTED "NO" AGAINST ANY GOAL SO FAR, PLEASE COMPLETE VARIANCE SHEET AT THE BACK OF THE PATHWAY BEFORE SIGNING ABOVE – THANK YOU

***** HAVE YOU COMPLETED THE LAST 4 & 12 HOURLY OBSERVATIONS? *****

VARIANCE ANALYSIS FOR THE DYING PATIENT

PATIENT NAME:..... UNIT NO: ..... DATE: OF BIRTH.....

DATE	WHAT VARIANCE OCCURRED?	WHY DID VARIANCE OCCUR?	ACTION TAKEN	INITIALS	TITLE