

## Central Coast Collaborative Pathway

SURNAME	D.O.B.	
FIRST NAMES	AGE	SEX
ADDRESS		
		POSTCODE
TELEPHONE	M.R.N.	

(Adapted from the Welsh ICP)

This Pathway is intended as a guide in providing care for the patient and his/her family in the last three days of life. This document is placed in the patient's notes upon commencement, and forms part of the medical record. The pathway can be commenced only with the confirmed authorisation of the patient's current VMO, Staff Specialist or General Practitioner.

Each professional is encouraged to exercise their own clinical judgement at all times.

### INSTRUCTIONS FOR USE

Place this document in patient's medical record.

**Section 1** is completed by an attending Medical Officer as the patient is entered onto the Pathway.

**Section 2** is completed by a Registered or Enrolled Nurse.

**Section 3** is completed upon the patient's death by the attending Nurse.

**Section 4 (Quality Indicators Chart)** is completed during care and after the patient's death by the attending Nurse, and a de-identified copy is faxed to the Central Coast Palliative Care Service.

**Section 5 (Comfort Assessment Chart)** is completed regularly by nursing staff, and is kept at the foot of the bed. A new chart is to be used each day.

**Progress notes** are used to record any symptom event or other issue.

### MANDATORY CRITERIA FOR COMMENCEMENT

**Patient is medically assessed to be dying, with death anticipated within the next 3 days;**

**And a "not for intubation / not for CPR" order is discussed and documented;**

**And at least two of the following apply to the patient:**

- ❖ Bedbound
- ❖ Semi-Comatose
- ❖ Only able to take sips of fluid
- ❖ No longer able to take tablets

**Note: The Central Coast Palliative Care Service** can be contacted at any time (24/7) on **4336 7777** to advise on any aspect of this pathway.

Binding Margin – Do Not Write

COLLABORATIVE PATHWAY

# Central Coast Collaborative Pathway

SURNAME

D.O.B.

FIRST NAMES

AGE

SEX

ADDRESS

POSTCODE

TELEPHONE

M.R.N.

## SECTION 1

This section to be completed and signed by the attending Medical Practitioner following consultation with the patient's VMO, Staff Specialist or General Practitioner.

(All "No"s to be documented in Progress notes.)

### Criteria for commencement of Collaborative Pathway

1. Patient is assessed as dying, death expected within 3 days. Yes ☐

2. Not for Intubation / Not for CPR order has been discussed with and agreed to by patient / carer. Yes ☐

3. At least TWO of the following (tick) :

Bedbound ☐

Only able to take sips of water ☐

Semi- Comatose ☐

No longer able to take tablets ☐

A. Current medication reviewed and non essentials discontinued Y ☐ N ☐

- Appropriate medications converted to subcutaneous route (Contact Central Coast Palliative Care Service for advice as needed)
- Syringe Driver commenced if indicated (See Policies and Guidelines)

B. PRN subcutaneous medication ordered as per Guidelines Y ☐ N ☐

C. Discontinue inappropriate investigations and observations Y ☐ N ☐

- Initiate Comfort Assessment Chart

Current condition and commencement of this Pathway has been discussed with

• Patient Y ☐ Unable ☐

• Primary Carer / Other Y ☐ Unable ☐

### Primary Carer Details:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Contact Phone Number/s \_\_\_\_\_

Contact Availability At anytime [ ☐ ] Not at night [ ☐ ]

Doctors Name

(print) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Binding Margin – Do Not Write

COLLABORATIVE PATHWAY

(attach patient sticker here)

<b>Central Coast Collaborative Pathway</b>	SURNAME	D.O.B.	
	FIRST NAMES	AGE	SEX
	ADDRESS		
			POSTCODE
	TELEPHONE		M.R.N.

## SECTION 2

This section to be completed by the attending Registered or Enrolled Nurse.  
(All "No"s to be documented in progress notes.)

### Spiritual /Religious /Cultural needs determined with Patient / Family /Carer and addressed

Y ☐ N ☐ N/A ☐

Special needs and/or rituals related to the dying and post death period identified and documented. Religious / pastoral resources contacted where indicated.

(Document relevant information)\_\_\_\_\_

### Initial concerns of Patient and /or Family /Carer identified and addressed

Y ☐ N ☐ N/A ☐

Issues raised relating to impending death and/or bereavement documented

\_\_\_\_\_  
\_\_\_\_\_

### Comfort Planning

Need for single room assessed Y ☐ N ☐ Need for special mattress assessed Y ☐ N ☐

Comfort Assessment Chart (SECTION 5) commenced Y ☐

Name (Print)\_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

## SECTION 3 – To be completed by nursing staff post death.

The deceased is cared for in accordance with Local Policy

Y ☐ N ☐

### Patient's Family / carer are kept informed and supported immediately after death

Was patient registered with the Central Coast Palliative Care Service (CCPCS)?

If No – please provide Family/Carer with Bereavement information

If Yes – please contact CCPCS on 43367777 ( 0830–1700 M-F) so that bereavement follow through can be arranged.

**SECTION 4 - (Quality Indicators Chart)** is finalised after the patient's death by the attending Nurse, and a de-identified copy is faxed to the CCPCS (4336 7773).

Name (Print)\_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Binding Margin – Do Not Write

COLLABORATIVE PATHWAY

## Binding Margin – Do Not Write

### Collaborative Pathway Quality Indicators Chart

(To be completed at conclusion of Pathway)

Item	Y or N please circle	Problem Description if N	Action Taken / Recommendation
Symptoms managed by guidelines	Y      N		
Comfort needs addressed by pathway	Y      N		
Spiritual / Cultural / needs addressed by pathway	Y      N		
Support needs addressed by pathway	Y      N		
Bereavement care facilitated by pathway	Y      N		
Other problems that were <u>not</u> addressed by pathway			
Overall death was satisfactory for Patient Family / Carer Staff	Y      N Y      N Y      N		

## COLLABORATIVE PATHWAY

<b>Central Coast Comfort Assessment Chart</b>		SURNAME			D.O.B.		
		FIRST NAMES			AGE	SEX	
		ADDRESS					
					POSTCODE		
		TELEPHONE			M.R.N.		
<p><b>Instructions: Score each box:</b>  <b>M for goal Met, U for goal Unmet, NA if Not Applicable</b>      <b>DATE:</b> _____          Record unmet goals in progress notes.          Note: 4th hourly while symptoms present. If symptom free for 24 hours, less frequent observation may be indicated</p>							
<b>SYMPTOMS</b>	<b>GOAL</b>	<b>0200</b>	<b>0600</b>	<b>1000</b>	<b>1400</b>	<b>1800</b>	<b>2200</b>
<b>PAIN</b>	No evidence of pain in last 4 hours						
<b>NAUSEA / VOMITING</b>	No episodes of nausea or vomiting in last 4 hours						
<b>RESPIRATORY</b>	No apparent distress or excessive secretions						
<b>AGITATION</b>	No visible restlessness or agitation						
<b>Other</b>							
<b>COMFORT MEASURES</b>	<b>GOAL</b>	<b>0200</b>	<b>0600</b>	<b>1000</b>	<b>1400</b>	<b>1800</b>	<b>2200</b>
<b>OPTIMAL POSITIONING</b>	Comfortable position maintained						
<b>MOUTH CARE</b>	Mouth / lips clean and moist						
<b>EYE CARE</b>	Eyes are clean and moist						
<b>SKIN CARE</b>	Skin is clean, moisturiser applied to dry areas.						
<b>MICTURITION</b>	Patient is dry and comfortable. Urinary aids used if incontinent / retention.						
<b>BOWEL CARE</b>	Patient is not agitated or distressed due to constipation or diarrhoea.						
<b>SUPPORT</b>	Patient and family / carer supported: Procedures explained; Information about changes provided; New concerns identified and responded to.						
<b>SPIRITUAL / CULTURAL NEEDS</b>	Identified Spiritual / Religious / Cultural needs / rituals are facilitated						
	<b>Nurse's Initials</b>						