

## LIVERPOOL CARE PATHWAY FOR THE DYING PATIENT (LCP) SUPPORTING CARE IN THE LAST HOURS OR DAYS OF LIFE

### Relative / Carer Information



The doctors and nurses will have explained to you that there has been a change in your relative or friend's condition. They believe that the person you care about is now dying and in the last hours or days of life.

The LCP is a document which supports the doctors and nurses to give the best quality of care. All care will be reviewed regularly.

You and your relative or friend will be involved in the discussion regarding the plan of care with the aim that you fully understand the reasons why decisions are being made. If your relative or friend's condition improves then the plan of care will be reviewed and changed. All decisions will be reviewed regularly. If after discussion with the doctors and nurses you do not agree with any decisions you may want to ask a second opinion.

#### Communication

There are information leaflets available for you as it is sometimes difficult to remember everything at this sad and challenging time. ('What to Expect when Someone is Dying' and 'Coping with Bereavement').

The team will ask for your contact details, as keeping you updated is a priority.

You will have the opportunity to discuss with the doctors and nurses, what is important to your relative or friend about their wishes, feelings, faith, beliefs and values.

#### Medication

Medication that is not helpful at this time may be stopped and new medications prescribed.

Medications for symptom control will only be given when needed.

#### Comfort

Staff will not want to intrude on your time with your relative or friend. They will make sure that as far as possible any needs at this time are met.

The team looking after your relative or friend will make regular assessments of their comfort.

You may want to be involved in elements of care at this time. You can support care in important ways such as spending time together, sharing memories and news of family and friends.

**Diminished need for food and drink**

Loss of interest in and a reduced need for food and fluids is part of the normal dying process. When a person stops eating and drinking it can be hard to accept even when we know they are dying. Your relative or friend will be supported to take food and fluids by mouth for as long as possible.

Decisions about the use of artificial fluids (a drip) will be made in the best interests of your relative or friend. Fluids given by a drip will only be used where it is helpful and not harmful. This decision will be explained to you and reviewed regularly.

Good mouth care is very important at this time. The nurses will explain to you how mouth care is given and may ask if you would like to help give this care.

**Caring well for your relative or friend is important to us. Please do not hesitate to speak with the doctors or nurses regarding any worries or concerns that you may have, no matter how insignificant you think they may be or how busy the staff may seem. This may be all very unfamiliar to you and we are here to explain, support and care.**

**Understanding the changes that may occur before death**

The time from the diagnosis of dying to the time of death is very difficult to predict. It may be a matter of hours or days or even longer. You may have anticipated this for some time now or this may be very new to you. Even when the person who is dying is settled and comfortable it can be painful for the relative or carer to watch their loved one at this time. Your relative or friend may spend more time sleeping and will often be drowsy when awake. Eventually the person may lapse into unconsciousness. When death is very close there may be changes to breathing, skin colour and temperature.



**Telephone Numbers**

We can be reached during daytime at: .....

Night time at: .....

Other information or contact numbers if applicable (e.g. Palliative Care Nurse, District Nurse):

.....  
.....

This space can be used for you to list any questions you may want to ask the doctors and nurses:

.....  
.....  
.....

## LIVERPOOL CARE PATHWAY FOR THE DYING PATIENT (LCP) SUPPORTING CARE IN THE LAST HOURS OR DAYS OF LIFE

### HEALTH CARE PROFESSIONAL INFORMATION

**As with all clinical guidelines and pathways the LCP aims to support but does not replace clinical judgement.**

- The LCP document guides and enables health care professionals to focus on care in the last hours or days of life. This guides the delivery of high quality care tailored to the patient's individual needs in the last days and hours of life, when their death is expected.
- Using the LCP in any care setting requires regular assessment that includes reflection, review and critical decision-making in the best interest of the patient by a team of health care professionals. All health care professionals must be cognisant of their scope of practice when using the LCP, including undertaking assessments, completing documentation and prescribing/administering medications.
- A robust continuous education and teaching programme must underpin the use of the LCP.
- The recognition and diagnosis of dying is always complex irrespective of previous diagnosis or history. Uncertainty is an integral part of dying, and there are occasions when a patient who is thought to be dying lives longer, or dies sooner, than expected. Seek a second opinion or specialist palliative care support as needed.
- Changes in care are made in the best interest of the patient and relative or carer. This needs to be reviewed regularly and discussed within the Multidisciplinary Team (MDT).
- Good, comprehensive, clear communication is pivotal and all decisions leading to a change in care delivery should be communicated to the patient where appropriate and to the relative or carer. The views of all concerned must be listened to and documented.
- If a goal on the LCP is not achieved this must be coded as a **VARIANCE**. Documenting a variance is a useful way of recording the decisions made for each patient based on their individual needs, your clinical judgement and the needs of the relative or carer.
- '**Symptom Control Guidelines**' are provided at the end of the LCP document. It is recommended these be adapted to reflect local practice to guide appropriate prescribing.
- The LCP does not preclude the use of clinically assisted nutrition, hydration or antibiotics. All clinical decisions must be made in the patient's best interest. A blanket policy of clinically assisted (artificial) nutrition or hydration, or of no clinically assisted nutrition or hydration, is ethically indefensible and in the case of patients lacking capacity is prohibited under the Mental Health (Compulsory Assessment and Treatment) Act (1992).
- In LCP Version 12, the term 'best interest' includes medical, physical, emotional, social, spiritual/religious and cultural factors relevant to the patient's welfare.
- The responsibility for the use of the LCP Version 12 document as part of a continuous quality improvement programme in New Zealand sits within the governance of the registered organisation. For more information contact the National LCP Office NZ [www.lcpnz.org.nz](http://www.lcpnz.org.nz)

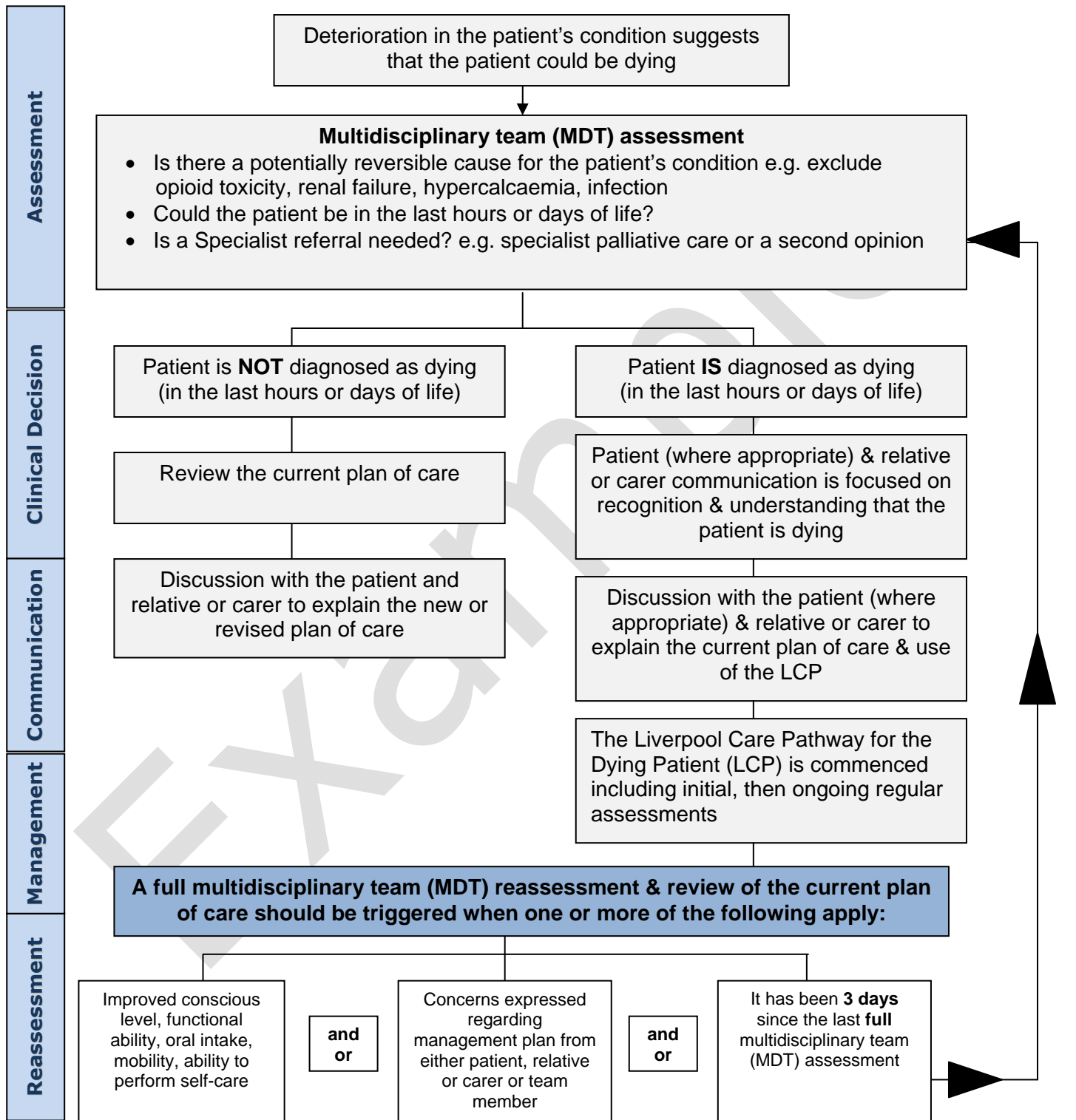
**The patient will be assessed regularly and a formal MDT review must be undertaken every 3 days.**

#### REFERENCES:

- Ellershaw, J.E; Wilkinson, S. (2003). *Care of the dying: A pathway to excellence*. Oxford University Press. Oxford.
- Public Act. (1992; No. 46). *Mental Health (Compulsory Assessment and Treatment) Act* (as at 1 July 2009) New Zealand.
- Minister of Health. (2001). *New Zealand Palliative Care Strategy*. Author: Wellington.
- National Institute for Clinical Excellence (2004) *Improving Supportive and Palliative Care for Adults with Cancer*. London, NICE MCPCIL (2009) *National Care of the Dying Audit Hospitals Generic Report Round 2*. [www.mcpcil.org.uk](http://www.mcpcil.org.uk)

## ALGORITHM (FLOW CHART)

### Decision making in diagnosing dying & use of the LCP to support care in the last hours or days of life



**Always remember that the Specialist Palliative Care Team are available for advice and support, especially if:**  
Symptom control is difficult and/or if there are difficult communication issues or you need advice or support regarding your care delivery supported by the LCP



<b>SECTION 1: INITIAL ASSESSMENT</b> <i>(to be completed by doctor and nurse)</i>																														
<b>DIAGNOSIS &amp; BASELINE INFORMATION</b>	PRIMARY DIAGNOSIS: ..... SECONDARY DIAGNOSIS: .....																													
	MEDICAL CONSULTANT/SPECIALIST: .....																													
	Ethnicity: ..... Female <input type="checkbox"/> Male <input type="checkbox"/> Age: .....																													
	<p><b>At the time of the assessment is the patient:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width: 33%;">In pain</td> <td style="width: 10%;">Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td style="width: 33%;">Able to swallow</td> <td style="width: 10%;">Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td style="width: 14%;">Confused</td> <td style="width: 10%;">Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> <tr> <td>Agitated</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>Continent (bladder)</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>Nauseated</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>Catheterised</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>Experiencing respiratory</td> <td></td> </tr> <tr> <td>Vomiting</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>Continent (bowels)</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>tract secretions</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> <tr> <td>Dyspnoeic</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>Constipated</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td></td> <td></td> </tr> </table> <p><b>Is the patient:</b> Conscious <input type="checkbox"/> Semi-conscious <input type="checkbox"/> Unconscious <input type="checkbox"/></p> <p>Experiencing other symptoms (e.g. oedema, itch) ..... Yes <input type="checkbox"/> No <input type="checkbox"/></p>	In pain	Yes <input type="checkbox"/> No <input type="checkbox"/>	Able to swallow	Yes <input type="checkbox"/> No <input type="checkbox"/>	Confused	Yes <input type="checkbox"/> No <input type="checkbox"/>	Agitated	Yes <input type="checkbox"/> No <input type="checkbox"/>	Continent (bladder)	Yes <input type="checkbox"/> No <input type="checkbox"/>			Nauseated	Yes <input type="checkbox"/> No <input type="checkbox"/>	Catheterised	Yes <input type="checkbox"/> No <input type="checkbox"/>	Experiencing respiratory		Vomiting	Yes <input type="checkbox"/> No <input type="checkbox"/>	Continent (bowels)	Yes <input type="checkbox"/> No <input type="checkbox"/>	tract secretions	Yes <input type="checkbox"/> No <input type="checkbox"/>	Dyspnoeic	Yes <input type="checkbox"/> No <input type="checkbox"/>	Constipated	Yes <input type="checkbox"/> No <input type="checkbox"/>	
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<b>COMMUNICATION</b>	<p><b>Goal 1.1: The patient is able to take a full and active part in communication.</b> Achieved <input type="checkbox"/> Variance <input type="checkbox"/> Unconscious <input type="checkbox"/></p> <p>Barriers that have the potential to prevent communication have been assessed. First language: ..... Other barriers to communication identified .....</p> <p>Consider: Hearing, vision, speech, learning disabilities, dementia (use of assessment tools), neurological conditions and confusion. The relative or carer may know how specific signs indicate distress if the patient is unable to articulate their own concerns.</p> <p>Consider need for an interpreter (contact no): .....</p> <p><b>Does the patient have:-</b></p> <p>An Advance Care Plan? .....</p> <p>An expressed wish for organ/tissue donation? .....</p> <p>An advance decision to refuse treatment? .....</p> <p>Does the patient have the capacity to make their own decisions on their own treatment at this moment in time? Consider the support of a court appointed Welfare Guardian (i.e. Enduring Power of Attorney (EPOA) and the Protection of Personal and Property Rights Act 1988). If required, document below how this is/has been addressed: Comments: .....</p>																													
<b>COMMUNICATION</b>	<p><b>Goal 1.2: The relative or carer is able to take a full and active part in communication.</b> Achieved <input type="checkbox"/> Variance <input type="checkbox"/></p> <p>First language ..... Other barriers to communication identified .....</p> <p>Consider need for an interpreter (contact no): .....</p> <p><b>Goal 1.3: The patient is aware that they are dying.</b> Achieved <input type="checkbox"/> Variance <input type="checkbox"/> Unconscious <input type="checkbox"/></p> <p><b>Goal 1.4: The relative or carer is aware that the patient is dying.</b> Achieved <input type="checkbox"/> Variance <input type="checkbox"/></p> <p><b>Goal 1.5: The clinical team have up to date contact information for the relative or carer as documented below.</b> Achieved <input type="checkbox"/> Variance <input type="checkbox"/></p> <p>1st contact name: .....</p> <p>Relationship to patient: ..... Phone (H) ..... (Mob) .....</p> <p>When to contact: At any time <input type="checkbox"/> Not at night-time <input type="checkbox"/> Stay overnight <input type="checkbox"/></p> <p>2nd contact name: .....</p> <p>Relationship to patient: ..... Phone (H) ..... (Mob) .....</p> <p>When to contact: At any time <input type="checkbox"/> Not at night-time <input type="checkbox"/> Stay overnight <input type="checkbox"/></p> <p><b>Next of kin:</b> (if different from above) N/A <input type="checkbox"/> <b>or</b> <b>Enduring Power of Attorney (EPOA):</b> N/A <input type="checkbox"/></p> <p>Name: ..... Name: .....</p> <p>Contact details: ..... Contact details: .....</p>																													

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<b>SECTION 1: INITIAL ASSESSMENT continued</b> <i>(to be completed by doctor and nurse)</i>	
	<p><b>Goal 2: The relative or carer has had a full explanation of the facilities available to them and a facilities leaflet has been given.</b> <span style="float: right;">Achieved <input type="checkbox"/> Variance <input type="checkbox"/></span></p> <p style="font-size: small;">Facilities may include: car parking, toilet, bathroom facilities, beverages, payphone, accommodation</p>
SPIRITUALITY / RELIGION	<p><b>Goal 3.1: The patient is given the opportunity to discuss what is important to them at this time eg. their wishes, feelings, faith, beliefs, values.</b> <span style="float: right;">Achieved <input type="checkbox"/> Variance <input type="checkbox"/> Unconscious <input type="checkbox"/></span></p> <p style="font-size: small;">Patient may be anxious for self or others. Consider specific religious and spiritual needs.</p> <p><b>Did the patient take the opportunity to discuss the above</b> <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/> Unconscious <input type="checkbox"/></span></p> <p><b>Religious tradition identified</b>, please specify: .....</p> <p>Patient's own Minister/Priest/Spiritual adviser: Name: .....</p> <p>Phone no: ..... Date/time: ..... Contacted <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>N/A</b> <input type="checkbox"/></p> <p>Support of the facility spiritual support team/person offered: <span style="float: right;"><b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>N/A</b> <input type="checkbox"/></span></p> <p>Facility spiritual support adviser: Name: .....</p> <p>Tel no: ..... Date/time: ..... Contacted <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>N/A</b> <input type="checkbox"/></p> <p><b>If patient's wishes are known re: burial or cremation, document at top of 'Section 3 - Care After Death'</b></p> <p>Needs now: .....</p> <p>Needs at death: .....</p> <p>Needs after death: .....</p>
	<p><b>Goal 3.2: The relative or carer is given the opportunity to discuss what is important to them at this time e.g. their wishes, feelings, faith, beliefs, values.</b> <span style="float: right;">Achieved <input type="checkbox"/> Variance <input type="checkbox"/></span></p> <p><b>Did the relative or carer take the opportunity to discuss the above</b> <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p> <p>Comments: .....</p> <p>.....</p> <p>.....</p>
CULTURAL NEEDS	<p><b>Goal 3.3: The patient is given the opportunity to discuss their cultural needs at this time.</b> <span style="float: right;">Achieved <input type="checkbox"/> Variance <input type="checkbox"/> Unconscious <input type="checkbox"/></span></p> <p>Comments.....</p> <p>Needs now:.....</p> <p>Needs at death:.....</p> <p>Needs after death:.....</p>
	<p><b>Goal 3.4: The relative(s) or carer(s) is given the opportunity to discuss their cultural needs at this time.</b> <span style="float: right;">Achieved <input type="checkbox"/> Variance <input type="checkbox"/></span></p> <p>Comments.....</p> <p>Needs now:.....</p> <p>Needs at death:.....</p> <p>Needs after death:.....</p>





<b>SECTION 1: INITIAL ASSESSMENT continued</b> <i>(to be completed by doctor and nurse)</i>		
<b>(Doctor to complete Goals 7)</b>	<p><b>Goal 7: The need for clinically assisted (artificial) hydration is reviewed by the MDT.</b> <span style="float: right;">Achieved <input type="checkbox"/> Variance <input type="checkbox"/></span></p> <p>The patient should be supported to take fluids by mouth for as long as tolerated. For many patients the use of clinically assisted (artificial) hydration will not be required. A reduced need for fluids is part of the normal dying process. Symptoms of thirst / dry mouth do not always indicate dehydration but are often due to mouth breathing or medication. Good mouth care is essential.</p> <p>If clinically assisted (artificial) hydration is already in place please record route: IV <input type="checkbox"/> S/C <input type="checkbox"/> PEG/PEJ <input type="checkbox"/> NG <input type="checkbox"/></p> <p>Is clinically assisted (artificial) hydration: Not required <input type="checkbox"/> Discontinued <input type="checkbox"/> Continued <input type="checkbox"/> Commenced <input type="checkbox"/></p> <p>Consider reduction in rate / volume according to individual need if hydration support is in place. If required consider the s/c route. Explain the plan of care to the patient (where appropriate) and the relative or carer.</p>	
<b>HYDRATION</b>		
<b>SKIN CARE</b>	<p><b>Goal 8: The patient's skin integrity is assessed.</b> <span style="float: right;">Achieved <input type="checkbox"/> Variance <input type="checkbox"/></span></p> <p>The aim is to prevent pressure ulcers or further deterioration if a pressure ulcer is present. Use a recognised risk assessment tool e.g. Waterlow / Braden Score to support clinical judgment. The frequency of repositioning should be determined by skin inspection, assessment and the patient's individual needs. Consider the use of special aids (mattress / bed).</p>	
<b>EXPLANATION OF THE PLAN OF CARE</b>	<p><b>Goal 9.1: A full explanation of the current plan of care (LCP goals of care) is given to the patient.</b> <span style="float: right;">Achieved <input type="checkbox"/> Variance <input type="checkbox"/> Unconscious <input type="checkbox"/></span></p> <p><b>Goal 9.2: A full explanation of the current plan of care (LCP goals of care) is given to the relative or carer.</b> <span style="float: right;">Achieved <input type="checkbox"/> Variance <input type="checkbox"/></span></p> <p>Name of relative(s) or carer(s) present and relationship to the patient: .....</p> <p>Names of health care professionals present: .....</p> <p>'Relative / Carer Information' sheet at front of the LCP given <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span></p> <p>Parents or carer should be given or have access to age appropriate advice and information to support children and adolescents.</p> <p><b>Goal 9.3: The LCP leaflets have been given to the relative or carer.</b> <span style="float: right;">Achieved <input type="checkbox"/> Variance <input type="checkbox"/></span></p> <p>i.e. 'What to Expect when Someone is Dying' and 'Coping with Bereavement' leaflets (or equivalent).</p> <p><b>Goal 9.4: The patient's primary health care team/GP practice is notified that the patient is dying.</b> <span style="float: right;">Achieved <input type="checkbox"/> Variance <input type="checkbox"/></span></p> <p>a) G.P. Practice to be contacted if unaware patient is dying. (if out of hours write in 'Variance Sheet' for staff to make contact next working day).</p> <p>b) Consider notifying the patient's medical specialists/consultants if unaware the patient is dying.</p>	
<b>If you have recorded a "VARIANCE" against any goal, complete VARIANCE SHEET for INITIAL ASSESSMENT.</b>		
<b>SIGNATURES</b>	Please sign here on completion of the 'Initial Assessment'	Please sign here on completion of the 'Initial Assessment'
	<p><b>Doctor's name (print):</b></p> <p>.....</p> <p><b>Doctor's signature:</b></p> <p>.....</p> <p><b>Date</b> ..... <b>Time</b> .....</p>	<p><b>Nurse's name (print):</b></p> <p>.....</p> <p><b>Nurse's signature &amp; designation:</b></p> <p>.....</p> <p><b>Date</b> ..... <b>Time</b> .....</p>



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<b>SECTION 1 VARIANCE ANALYSIS FOR INITIAL ASSESSMENT</b>		
<b>WHAT VARIANCE OCCURRED &amp; WHY?</b> (what was the issue?)	<b>ACTION TAKEN</b> (what did you do?)	<b>OUTCOME</b> (did this solve the issue?)
Signature .....	Signature .....	Signature .....
Date/time .....	Date/time .....	Date/time .....
Signature .....	Signature .....	Signature .....
Date/time .....	Date/time .....	Date/time .....
Signature .....	Signature .....	Signature .....
Date/time .....	Date/time .....	Date/time .....
Signature .....	Signature .....	Signature .....
Date/time .....	Date/time .....	Date/time .....
Signature .....	Signature .....	Signature .....
Date/time .....	Date/time .....	Date/time .....

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<b>SECTION 1 VARIANCE ANALYSIS FOR INITIAL ASSESSMENT</b>		
<b>WHAT VARIANCE OCCURRED &amp; WHY?</b> (what was the issue?)	<b>ACTION TAKEN</b> (what did you do?)	<b>OUTCOME</b> (did this solve the issue?)
Signature .....	Signature .....	Signature .....
Date/time .....	Date/time .....	Date/time .....
Signature .....	Signature .....	Signature .....
Date/time .....	Date/time .....	Date/time .....
Signature .....	Signature .....	Signature .....
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Signature .....	Signature .....	Signature .....
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Signature .....	Signature .....	Signature .....
Date/time .....	Date/time .....	Date/time .....

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**Date:** ..... **Day:** .....

**SECTION 2 ONGOING ASSESSMENT OF THE PLAN OF CARE**

**Undertake an MDT assessment & review of the current management plan if:**

Improved conscious level, functional ability, oral intake, mobility, ability to perform self-care

and  
or

Concern expressed regarding management plan from either the patient, relative or team member

and  
or

It has been 3 days since the last full MDT assessment

**Consider the support of the specialist palliative care team and/or a second opinion as required. Document all reassessment dates and times on page 3 of this document.**

*Codes to be recorded at each timed assessment (a moment in time) A= Achieved V = Variance (i.e. exception reporting)*

	0400	0800	1200	1600	2000	2400
<b>Goal a: The patient does not have pain</b> Verbalised by patient if conscious, pain free on movement. Observe for non-verbal cues. Consider need for positional change. Use an appropriate pain assessment tool if appropriate. Consider PRN analgesia for incident pain.						
<b>Goal b: The patient is not agitated</b> Patient does not display signs of restlessness or distress, exclude reversible causes e.g. retention of urine, opioid toxicity.						
<b>Goal c: The patient does not have respiratory tract secretions</b> Consider positional change. Discuss symptom & plan of care with patient, relative or carer. Medication more effective when given as soon as symptom occurs.						
<b>Goal d: The patient does not have nausea</b> Verbalised by patient if conscious.						
<b>Goal e: The patient is not vomiting</b>						
<b>Goal f: The patient is not breathless</b> Verbalised by patient if conscious, consider positional change and use of a fan.						
<b>Goal g: The patient does not have urinary problems</b> Use of pads, urinary catheter as required.						
<b>Goal h: The patient does not have bowel problems</b> Monitor - constipation / diarrhoea. Monitor skin integrity. Bowels last opened: .....						
<b>Goal i: The patient does not have other symptoms</b> Record symptom here: ..... <b>If no other symptoms present - record N/A</b>						
<b>Goal j: The patient's comfort &amp; safety regarding the administration of medication is maintained</b> The patient is only receiving medication that is beneficial at this time. If CSCI via syringe driver in place a monitoring sheet must be in progress. S/C butterfly in place for PRN medication (if required) <b>If no medication required - record N/A</b>						

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Date: ..... Day: .....

<b>SECTION 2 ONGOING ASSESSMENT OF THE PLAN OF CARE continued</b>						
<i>Codes to be recorded at each timed assessment (a moment in time) A= Achieved V = Variance (i.e. exception reporting)</i>						
	<b>0400</b>	<b>0800</b>	<b>1200</b>	<b>1600</b>	<b>2000</b>	<b>2400</b>
<p><b>Goal k: The patient receives fluids to support their individual needs</b> The patient is supported to take oral fluids / thickened fluids for as long as tolerated. Monitor for signs of aspiration and/or distress. If appropriate consider clinically assisted (artificial) hydration. If in place monitor &amp; review rate/volume. Explain the plan of care with the patient and relative or carer.</p>						
<p><b>Goal l: The patient's mouth is moist and clean</b> See mouth care policy. Relative or carer involved in care giving as appropriate.</p>						
<p><b>Goal m: The patient's skin integrity is maintained</b> The frequency of assessment, repositioning &amp; special aids (eg. an air mattress) should be determined by skin inspection and the patient's individual needs. <i>Waterlow /Braden score:.....</i></p>						
<p><b>Goal n: The patient's personal hygiene needs are met</b> Skin care according to individual needs. Relative or carer involved in care giving as appropriate.</p>						
<p><b>Goal o: The patient receives their care in a physical environment adjusted to support their individual needs.</b> Consider physical environment &amp; space at bedside. Ensure nurse call bell accessible. RESTRAINT – Follow local policy/procedure. If 'in place' report on as a 'Variance'.</p>						
<p><b>Goal p: The patient's psychological well-being is maintained</b> Respectful verbal and non-verbal communication, use of listening skills, information and explanation of care given. Use of touch if appropriate. For spiritual/religious needs – consider support of the chaplaincy team.</p>						
<p><b>Goal q: The well-being of the relative or carer attending the patient is maintained</b> For spiritual/religious needs – support of chaplaincy team may be helpful. Listen &amp; respond to worries/fears. Age appropriate advice &amp; information to support children/adolescents made available to parents or carers.</p>						
<p><b>Goal r: The patient's cultural needs are met</b> Cultural needs are recorded (Goal 3.3), referred to, reviewed as necessary &amp; respected.</p>						
<p><b>Goal s: The relative(s) or carer(s) cultural needs are met</b> Cultural needs are recorded (Goal 3.4), referred to, reviewed as necessary &amp; respected.</p>						
<p><b>Signature of the health care professional making the assessment</b></p>						
<p><b>Signature of the Registered Nurse with delegated authority (where appropriate)</b></p>						





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**SECTION 2 & 3 VARIANCE ANALYSIS SHEET**

A **VARIANCE** is not just recorded at assessment times but **at any time** you see a change.

WHAT VARIANCE OCCURRED & WHY? (what was the issue?)	ACTION TAKEN (what did you do?)	OUTCOME (did this solve the issue?)
<p>Signature .....</p> <p>Date/time .....</p>	<p>Signature .....</p> <p>Date/time .....</p>	<p>Signature .....</p> <p>Date/time .....</p>
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ORGANISATION'S  
LOGO



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LOGO



**Section 3: CARE AFTER DEATH**

<b>VERIFICATION OF DEATH</b>	<b>NURSES NOTES</b>	Time of the patient's death: ..... Date of patient's death: ...../...../..... <b>Burial</b> <input type="checkbox"/> or <b>Cremation</b> <input type="checkbox"/> Persons present at time of death: ..... Relative or carer present at time of death: Yes <input type="checkbox"/> No <input type="checkbox"/> If not present, has the relative or carer been notified Yes <input type="checkbox"/> No <input type="checkbox"/> Name of person informed:.....Relationship to the patient:..... Contact number:..... Name of patient's Consultant /GP:..... Pager No:..... Tel No:.....
	<b>DOCTORS NOTES</b>	Date & Time Death Verified: ..... Cause of death: ..... Is the coroner likely to be involved: Yes <input type="checkbox"/> No <input type="checkbox"/> Comments: ..... Doctors Name: ..... Doctors Signature:..... Pager or contact phone no:.....
<b>PATIENT &amp; FAMILY / WHĀNAU CARE &amp; DIGNITY</b>	<b>Goal 10: Last offices (i.e. care of the deceased/tūpāpaku) are undertaken according to policy and procedure.</b> <b>Achieved</b> <input type="checkbox"/> <b>Variance</b> <input type="checkbox"/> The body/tūpāpaku is treated with respect and dignity Universal precautions adhered to Spiritual, religious, cultural rituals/needs met (Refer to patient & relative/carer wishes in Goals 3.1, 3.2, 3.3, & 3.4) Organisational policy followed for the management of ICD's, where appropriate Organisational policy followed for the management & storage of patient's valuables and belongings	
	<b>Goal 10.1: Arrangements for blessing room/bedspace made.</b> <b>Achieved</b> <input type="checkbox"/> <b>Variance</b> <input type="checkbox"/> <b>Not required</b> <input type="checkbox"/> Karakia / prayer are offered in respect of cultural needs of family/whānau	
<b>RELATIVE OR CARER INFORMATION</b>	<b>Goal 11: The relative or carer can express an understanding of what they will need to do next and are given relevant written information.</b> <b>Achieved</b> <input type="checkbox"/> <b>Variance</b> <input type="checkbox"/> Explanation regarding how to contact the funeral director to make an appointment regarding the death certificate and patient's valuables / belongings where appropriate 'Coping with Bereavement' (or equivalent) leaflet given      Yes <input type="checkbox"/> No <input type="checkbox"/> 'Before Burial or Cremation' booklet (by NZ Dept of Internal Affairs) given      Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Discuss as appropriate:</b> <ul style="list-style-type: none"> <li>• wishes regarding tissue/organ donation</li> <li>• viewing the body / tūpāpaku</li> <li>• the need for removal of cardiac devices</li> <li>• the need for a post mortem</li> <li>• the need for a discussion with the coroner</li> </ul> Information given to families/whānau on child bereavement services where appropriate	
<b>ORGANISATION INFORMATION</b>	<b>Goal 12.1: The primary health care team / GP is notified of the patient's death.</b> <b>Achieved</b> <input type="checkbox"/> <b>Variance</b> <input type="checkbox"/> The primary health care team / GP may have known this patient very well and other relatives or carers may be registered with the same GP. Telephone or fax the GP practice	
	<b>Goal 12.2: The patient's death is communicated to appropriate services across the organisation.</b> <b>Achieved</b> <input type="checkbox"/> <b>Variance</b> <input type="checkbox"/> e.g. palliative care team / district nursing team / hospice service (where appropriate) are informed of the death The patient's death is entered on the organisations IT system	
<b>If you have recorded a "VARIANCE" against any goal, complete VARIANCE SHEET before signing below.</b>		
Health Care Professional's Signature:	..... <b>Title:</b> ..... <b>Date:</b> .....	

**Please refer to Symptom Control Guidelines**

Example

# PAIN

## PATIENT IS IN PAIN

Assess and review cause of pain

**Is patient already taking oral morphine?**  
*(If already taking alternative opioid, contact your Specialist Palliative Care Service for advice)*

**YES**

**NO**

1. Consider dose increase of 30% in view of pain
2. Prescribe PRN doses of morphine, refer to calculation box •
3. To convert from oral morphine to S/C, via syringe driver refer to calculation box \*
4. Assess and review. If pain persists contact your Specialist Palliative Care Service for further advice.

1. If no contraindications, prescribe & administer Morphine 2.5mg – 5mg 4 hourly S/C PRN.
2. Review medication. If three or more PRN doses required, then consider continuous infusion or morphine via syringe driver.
3. If pain persists refer to "Yes" box.

## PATIENT'S PAIN IS CONTROLLED

**Is patient already taking oral morphine?**  
*(If already taking alternative opioid, contact your Specialist Palliative Care Service for advice)*

**YES**

**NO**

1. Prescribe PRN doses of morphine, refer to calculation box •
2. To convert from oral morphine to S/C morphine, via syringe driver refer to calculation box \*
3. If pain not controlled refer to 'patient is in pain'

1. If no contraindications, prescribe Morphine 2.5mg – 5mg 4 hourly S/C PRN.
2. If pain occurs refer to 'patient is in pain' box.

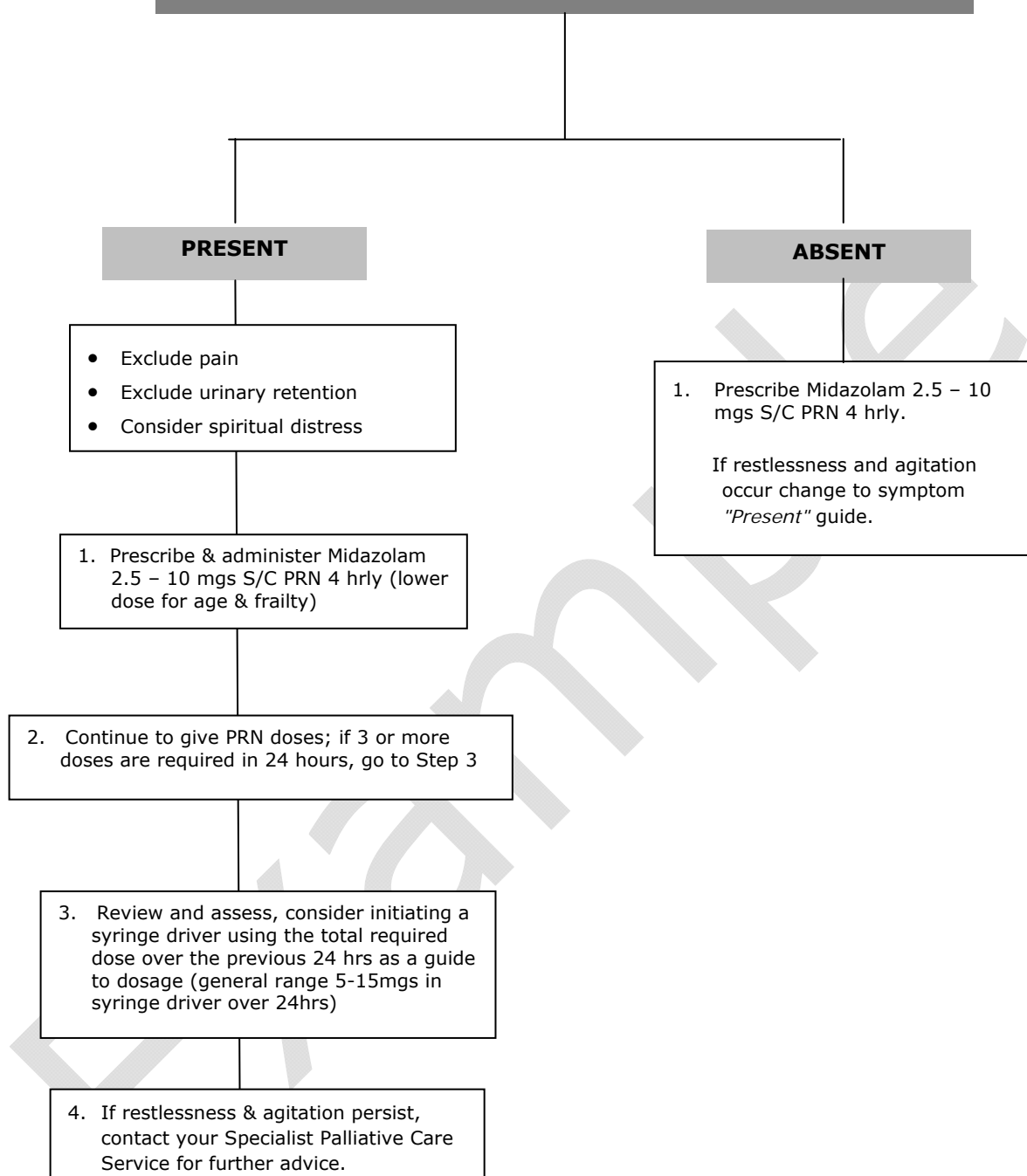
**NB:**  
*S/C (Subcutaneous)*  
*PRN (as required)*

### MORPHINE CALCULATIONS

- \* To convert from oral morphine to morphine S/C via syringe driver, halve the **total 24 hour** dose of oral morphine e.g. 60 mg oral morphine over 24 hours = 30 mg of S/C morphine over 24 hours.
- PRN doses of morphine should be one-sixth of the **24 hour dose** in the syringe driver e.g. morphine 30 mg S/C via a syringe driver will require 5 mg morphine S/C PRN 4hrly.

**Please note: If you require further advice at any time 24hrs a day, 7 days a week please contact your Specialist Palliative Care Service**

## TERMINAL RESTLESSNESS & AGITATION



**NB:**  
*S/C (Subcutaneous)*  
*PRN (as required)*

**Please note: If you require further advice at any time 24hrs a day,  
 7 days a week please contact your Specialist Palliative Care Service**

**Early intervention may enable more successful management of this symptom**

## RESPIRATORY TRACT SECRETIONS

### PRESENT

- Explain symptom to family and whānau
- Re-position patient
- If persistent & causing distress move to next step

1. Prescribe / apply Scopolamine patch 1x over 72hrs (3days) (if available) **and** prescribe PRN Hyoscine-N- Butylbromide 20mgs S/C 4hrly
2. Assess **2hrs** after applying Scopolamine patch, if symptoms persist also administer stat Hyoscine-N- Butylbromide as charted (leave Scopolamine insitu).

3a. Assess - if symptoms persist and stat dose of Hyoscine-N- Butylbromide **was** helpful.

Consider syringe driver, with Hyoscine-N- Butylbromide 60-80 mgs over 24 hours (leave Scopolamine insitu)

3b. Assess - if symptoms persist and stat dose of Hyoscine-N- Butylbromide **was not** helpful.

Contact your Specialist Palliative Care Service for further advice

### ABSENT

1. Prescribe Scopolamine patch PRN & Hyoscine-N- Butylbromide 20mgs S/C PRN 4hrly

If respiratory tract secretions occur change to symptom "Present" guide

**NB:**  
 S/C (Subcutaneous)  
 PRN (as required)

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## NAUSEA & VOMITING

### PRESENT

1. Prescribe and administer Levomepromazine 3.125 - 6.25mgs S/C PRN 8 hourly.

2. Consider regular administration via syringe driver if symptom persists. i.e. Levomepromazine 6.25 mg over 24 hours.

3. Review dosage after 24hrs.

4. If symptoms persist, consider increasing dose (ie 12.5mgs Levomepromazine over 24hrs)

5. If symptoms persist contact your Specialist Palliative Care Service for further advice.

### ABSENT

1. Prescribe Levomepromazine 3.125 - 6.25mgs S/C 8hly PRN.

If symptoms occur change to symptom 'Present' guideline.

**NB:**  
*S/C (Subcutaneous)*  
*PRN (as required)*

**Please note: If you require further advice at any time 24hrs a day 7 days a week please contact your Specialist Palliative Care Service**

*Differentiate between dyspnoea, respiratory tract secretions & laboured breathing*

## DYSPNOEA

### PRESENT

Is patient already taking oral morphine for breathlessness?

Yes

1. Convert to S/C Morphine, prescribe & administer PRN 4hrly

No

1. Prescribe & administer Morphine 2.5mg – 5mg S/C PRN 4hrly, for dyspnoea

### ABSENT

Is patient already taking oral morphine?

Yes

Prescribe appropriate PRN Morphine dose for pain or dyspnoea

No

Prescribe Morphine 2.5mg – 5mg S/C PRN 4hrly for dyspnoea

2. Assess, if still dyspnoeic, consider adjusting morphine dose and/or administering via syringe driver

If dyspnoeic **and anxious**:

- Consider adding Midazolam 2.5mg – 5mg S/C PRN 4hrly
- Consider continuous infusion of Midazolam 5-15mg via Syringe Driver (lower dose for age & frailty)

3. If dyspnoea persists contact your Specialist Palliative Care Service for further advice

**NB:**  
S/C (Subcutaneous)  
PRN (as required)

### MORPHINE CALCULATIONS

- \* To convert from oral morphine to morphine S/C via syringe driver, halve the **total 24 hour** dose of oral morphine e.g. 60 mg oral morphine over 24 hours = 30 mg of S/C morphine over 24 hours.
- PRN doses of morphine should be one-sixth of the **24 hour dose** in the syringe driver e.g. morphine 30 mg S/C via a syringe driver will require 5 mg morphine S/C PRN 4hrly.

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