Care Plan for End of Life

(A hospital label may be placed here where applicable)

Print Name_____ NHS No_____

Date of Birth_____ Ward/Place of Care_____

GP/Consultant_____ Contact details_____

District Nurse/ Clinical Nurse Specialist _____

Contact Details_____

Date started:_____ Time:_____

Doctor's name_____Signature_____

Nurse's name _____Signature_____

If this care plan is discontinued please record below:

Date of discontinuation: _____ Time_____

Please provide rationale for discontinuing:

(*further supporting documentation can be provided using the continuation sheets p15)*

Where to get further advice and support:

In Hours Advice	Out of Hours Advice from your local Hospice
Macmillan Specialist Palliative Care Team (*Mon-Fri 9-5)* Tel 01625 663177 **Macmillan Lung Cancer Team (*Mon-Fri 9-5*) Tel 01625 661997**	**East Cheshire Hospice Helpline (24 hour advice available) Tel 01625 666999** **St Luke's Hospice Helpline (24 hour advice available) Tel 01606 555489**

Also refer to: Cheshire EPAIGE : www.cheshire-epaige.nhs.uk

GMC Guidance: Treatment & Care Towards the End of Life (London 2010)

Leadership Alliance for the Care of Dying People- Priorities for Caring for the Dying Person; Duties & Responsibilities of Health & Care Staff (2014) Further advice concerning use of this care plan can be obtained by contacting the Service Development Team- End of Life Partnership Tel 01270 758120

Chaplaincy contact details – via switchboard at Macclesfield Hospital

5 Priorities for Care of the Dying Person

Duties and Responsibilities for Health & Care Staff

(Leadership Alliance for Care of the Dying 2015)

RECOGNISE	The possibility that the person is dying is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly Always consider reversible causes e.g. infection, dehydration, hypercalcaemia, etc
COMMUNICATE	Sensitive communication takes place between staff and the dying person, and those identified as important to them
INVOLVE	The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants
SUPPORT	The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible
PLAN & DO	An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, coordinated and delivered with compassion

Additional Pages

Please refer to www.cheshire-epaige.nhs.uk and click on 'Care Plan for End of Life' on the homepage to access:

- Separate guidance notes for professionals
- Separate guidance notes for members of the public
- Separate family documentation sheets/ continuation sheets/ assessment sheets/ review sheets
- Specialist care plan inserts for clinical areas such as Intensive Care Unit, Oral Care
- Family communication diary (optional)

Further advice concerning use of this care plan can be obtained by contacting the Service Development Team- End of Life Partnership Tel 01270 758120

Medical Assessment & Plan

NB: A lead Clinician (ST3 or above) MUST authorise commencement of this Care Plan

1. Initial Assessment Including Lasting Power of Attorney *(where applicable)*
2. Communication, Choices & Preferences
3. Daily Review & Delegated Responsibility
4. Management Plan
    - DNACPR
    - Implantable Cardio-Defibrillator (where applicable)
    - Suitability for Nurse Verification of Expected Death
    - Continuation/Discontinuation of Interventions
    - Hydration & Nutrition
    - Preferred Place of Death
    - Symptom Management including Anticipatory Prescribing

Name: Date of Birth: NHS No:

GUIDANCE FOR PRESCRIBING SUB-CUTANEOUS ANTICIPATORY MEDICATIONS

FOR PATIENTS WITH RENAL FAILURE REDUCED DOSES MARKED †

DISCUSS WITH PHARMACIST OR SPECIALIST PALLIATIVE CARE IF SEVERE LIVER IMPAIRMENT

Drug (ampoule size)	**Indication** *Notes*	**"When required" subcutaneous (SC) dose**	**24hr dose in SC Syringe Pump**	**TOTAL max 24hr dose**
Nausea & Vomiting (Determine the cause of the nausea to guide prescribing choice)				
Levomepromazine (25mg/1ml) 1st line if unknown cause	Broad spectrum anti-emetic. *Sedative. Caution in Parkinson's disease and epilepsy. Also used for terminal agitation.*	**5mg to 12.5mg 4hrly**	**6.25-25mg**	**25mg#**
Cyclizine (50mg/1ml)	Visceral distortion/ distension, cerebral irritation, airways irritation. *Caution in severe CCF.*	**50mg 4hrly**	**100-150mg** Dilute with water	**150mg#**
Haloperidol (5mg/1ml)	Biochemical disturbance (drug, metabolic, toxic). *Risk of extrapyramidal side effects (avoid in Parkinson's).*	**0.5-1.5mg 4-6hrly** 0.5mg if elderly/ CrCl<10ml/min†	**1.5-5mg**	**5mg#**
Metoclopramide (10mg/1ml)	Gastric stasis, reflux, "squashed stomach", ascites. *Avoid in GI obstruction/perforation/ haemorrhage. Risk of extrapyramidal side effects (avoid in Parkinson's, caution in age<20).*	**10mg 6hrly**	**30mg**	**80mg#**
Terminal Agitation *(NB – identify and treat reversible causes)*				
Midazolam (10mg/2ml) 1st line choice	Sedative/anxiolytic. Also anticonvulsant; for myoclonus; muscle relaxant.	**2.5-5mg 2hrly**	**10mg †** May need lower in renal failure	**60mg#**
	10mg IM may be used for major bleed/ catastrophic event – write separately on prescription chart if required.			
Levomepromazine (25mgs/1ml)	Antipsychotic - agitated delirium. *Seek specialist palliative care advice if using for agitation. Also used as an anti-emetic.*	**12.5-25mg 4hrly †** 2.5-5mg if CrCl<10ml/min	**25mg †** May need lower in renal failure	**200mg#**
Moist Noisy Breathing/Excessive Respiratory Secretions				
Glycopyrronium 200microgram/1ml	Reduces saliva secretion and volume of bronchial secretions. *Also used in bowel colic.*	**200mcg 3hrly**	**600mcg**	**1200mcg**
Pain and/or Dyspnoea: Doses for opioid naïve. If currently on opioid see pain algorithm on page 21				
Morphine (10mg/ml, 30mg/ml) 1st line choice	Strong opioid. **Due to volume if bolus >60mg or >360mg in a syringe pump, switch to diamorphine. May accumulate in renal/liver impairment*.	**2.5mg-5mg 2-4hourly** † eGFR 30-50ml/min: 75% dose *or* consider oxycodone eGFR <30ml/mi: oxycodone preferred, seek specialist advice	**10mg**	**Titrate as needed**
Oxycodone (10mg/ml, 50mg/ml)	Strong opioid. Use if morphine allergy or eGFR<30ml/min.	**2.5mg 2-4hourly**	**5-10mg**	**Titrate**
Diamorphine (5, 10, 30, 100mg vial)	Strong opioid. Use if volume of morphine unsuitable (see above*).	**2.5mg 2-4hourly**	**5-10mg**	**Titrate**

Higher doses may be used on Specialist Palliative Care Advice.

Table updated by H Wilson (Lead Macmillan Pharmacist): Based on Blue Booklet: Symptom Control Prescription Drugs and Administration Record (Version 10, June 2018)

Name: Date of Birth: NHS No:

SECTION 1 – Initial Assessment

Before commencing this care plan and during reassessment please refer to the CRITERIA below. Part 2 to be completed on 1st initiation:

Part 1

The team caring for the person have discussed and agreed that their condition is deteriorating, and death is likely within hours or a small number of days

1. Look for and treat reversible causes of symptoms if it would benefit the patient at this time
2. If uncertainty exists, or expertise is required, obtain specialist opinion from consultant team experienced in the person's condition
3. If complex and/or uncontrolled symptoms, obtain advice from the Specialist Palliative Care Team
4. Where applicable inform the individual's GP
5. Check for an Advance Care Plan or Advance Decision to Refuse Treatment, and use it to guide care appropriately
6. Check for a Lasting Power of Attorney (LPA) for health & welfare who has the right to make decisions relating to life-sustaining treatment (see page 9 for details of LPA). See www.cheshire-epaige.nhs.uk for further guidance on LPA's

Part 2

MULTIDISCIPLINARY TEAM INITIAL ASSESSMENT:

AUTHORISING LEAD CLINICIAN *(this must be authorised by ST3 or above)*

Name of Lead Clinician_____ Role_____

Date of initial assessment: _____ **Time** (*24hr clock*)_____

Details of other clinicians involved in the initial assessment where a decision has been made to commence the Care Plan *(including where applicable the Doctor who has obtained senior authorisation):*

Name_____ Signature_____Role_____

Name_____ Signature_____Role_____

Name_____ Signature_____Role_____

Name_____ Signature_____Role_____

Lasting Power of Attorney for Health & Welfare *(where applicable)*

Name of LPA…….. Contact Details……

Please sign below to confirm that relevant documentation has been seen, and is valid to support LPA for Health & Welfare. This LPA should then be flagged according to organisational procedures e.g. hospital notes, EMIS web template

Signature_____ Role_____ Date/time *(24hr clock)*_____

Section 2- COMMUNICATION, PREFERENCES & CHOICES

COMMUNICATION

Where the team have identified that an individual under their care is deteriorating and likely to be dying, they must discuss and agree a care plan with the individual (where possible) and with their family/significant others. **Wherever possible this should be done in-hours and by the team that know the person best.** The **Doctor (ST3 or above) should take overall responsibility for the decision to commence this care plan.** The agreed plan of care should clarify the following:

- Recognition of deterioration and the rationale for the belief the individual is now dying
- Acknowledgement of the uncertainty that can exist concerning a person's prognosis
- The individual's understanding and wishes for their treatment and care
- Are there any concerns/ questions from the individual, or their family/significant others
- Any communication difficulties to consider e.g. deafness, speech difficulties.
- Is there a patient passport or is an interpreter required?

PREFERENCES & CHOICES

Where the person is able, **THEY SHOULD BE GIVEN THE OPPORTUNITY TO DISCUSS WHAT IS IMPORTANT TO THEM**. The choices available to the individual should be clearly explained. Examples of choices that the individual may wish to discuss include:

- **Nominating a person(s) to be involved in their plan of care and with whom they wish information to be shared concerning their condition**
- **Where they would like to die (preferred place of death)**
- **Religious and/or spiritual requests**
- **Organ and tissue donation**

If the person lacks capacity or is unconscious, check whether they have previously expressed a preference pertaining to their end of life care. This information may be contained within:

- **In an Advance Statement of Wishes e.g. Preferred Priorities for Care (PPC)**
- **In an Advanced Decision to Refuse Treatment (ADRT)**
- **Through a legally appointed Lasting Power of Attorney for Health & Welfare**
- **In a Patient Passport/ Person Centred Plan**

For individuals who are assessed to be lacking capacity and have no-one else to support them (other than paid staff), **please consult with the IMCA service*.**

The availability of an IMCA should not preclude the delivery of good quality end of life care

ADVANCE DECISION TO REFUSE TREATMENT (ADRT) (where applicable)

Please sign below to confirm that valid and applicable documentation has been seen to support an ADRT. **Give details re the ADRT overleaf and flag according to organisational procedures e.g. hospital notes, EMIS web template**

Signature_____ **Role**_____

Location of ADRT_____ **Date/time *(24hr clock)*** _____

This section should be used to detail discussions that have been held with both the patient and their family/significant others including the outcomes of any discussions that have been led by other members of the multi-professional team.

Page 6 should be used as a prompt to guide discussions and to ensure all relevant areas are well documented.

Date/Time of completion: *(24hr clock)*			
Please indicate that the outcomes of these discussions have been communicated to relevant staff	**Yes**	**No**	**Unknown**

Notes: COMMUNICATION, PREFERENCES & CHOICES	**Signature/Role**

Name: Date of Birth: NHS No:

Section 3- DAILY REVIEW & DELEGATED RESPONSIBILITY

Review of this plan of care MUST take place on a DAILY basis (or before if an improvement in the person's condition /functional status is observed **OR** if any concerns are expressed regarding the current plan of care).

INSTRUCTIONS FOR THE DAILY REVIEW

- The daily review must be completed by a Senior Doctor (ST3 or above), **OR** by a competent clinician to whom **responsibility has been delegated.**
- The review should determine that the individual is still thought to be in the last hours or days of life and that the plan of care therefore remains appropriate
- The experience and opinions of the wider multidisciplinary team should be sought
- Goals of care should be clearly and sensitively discussed and agreed with the dying person (if conscious), and with their nominated family/significant others, (unless they have expressed a wish not to participate in such conversations)

NB: The senior clinician remains accountable, alongside their delegate, for decisions made on their behalf.

Delegated Responsibility- Please detail or tick below the staff members or staff groups to whom the senior clinician is happy to delagate responsibility for the daily review

	Tick	Date
Community Nursing Team		
Ward/Department Nursing Staff		
Macmillan/Specialist Nurses		
Hospice Nurses		
Care Home Nurse in Charge		
Junior Medical Staff		
Other: *Please specify*		

PLEASE NOTE THAT IF THIS SECTION IS NOT COMPLETED STAFF WILL BE ADVISED TO REQUEST A SENIOR DOCTOR TO CARRY OUT THE DAILY REVIEW

TO BE COMPLETED DURING EACH DAILY REVIEW (if completed by Medical Staff)

Senior Clinician (*or person with delegated responsibility***):**
Name_____Signature_____Role_____Date/Time_____

Senior Clinician (*or person with delegated responsibility***):**
Name_____Signature_____Role_____Date/Time_____

Senior Clinician (*or person with delegated responsibility***):**
Name_____Signature_____Role_____Date/Time_____

Senior Clinician (*or person with delegated responsibility***):**
Name_____Signature_____Role_____Date/Time_____

Spare daily review sheets available via www.cheshire-epaige.nhs.uk

Section 4- MANAGEMENT PLAN

DO NOT ATTEMPT CARDIO-PULMONARY RESUSCITATION (DNACPR)

This should be discussed and recorded in the medical record as per policy. **A LILAC DO NOT ATTEMPT RESUSCITATION FORM MUST ALSO BE COMPLETED**

For those who lack capacity and have no-one else to support them (other than paid staff), an *** IMCA MUST be consulted. ***_The availability of an IMCA should not preclude making a DNACPR decision whereby the decision is unquestionably on medical grounds i.e. there are no benefits and burdens to weigh up_

Please indicate that the lilac uDNACPR form has been completed ☐

Does this person have an IMPLANTABLE CARDIOVERTER DEFIBRILLATOR (ICD) in situ? *If yes, refer to local policy re deactivation, & contact the individual's cardiology team in hours* **Yes No**

Where applicable give details of actions taken to facilitate deactivation of ICD:

…….....

……

NURSE VERIFICATION OF EXPECTED DEATH

This patient is suitable for Nurse Verification of expected death, if a suitably qualified nurse trained in 'Nurse Verification of Expected Death' is available Yes/ No

FOR COMMUNITY & CARE HOMES ONLY:
After death the undertaker can remove the body. The GP will issue a death certificate as soon as is practicable.

GP signature……..……..

Date/time ……

GP Name (please print)…….…… …….

Surgery Name and Address…….

MEDICAL AND NURSING INTERVENTIONS TO BE CONTINUED AND/ OR DISCONTINUED:

Date/time	Notes	Signature/role

PLEASE NOTE:

FOOD AND DRINK should be continued for as long as the person can tolerate/ desires this.

- If the individual is having difficulty swallowing ordinary fluids, consider using a thickener and monitor for signs of aspiration (eg coughing, bubbly breathing). If the person is conscious and wishes to continue small sips of fluid although aware there is a risk of it going "the wrong way", they should be supported in this**.**
- If a swallowing assessment is thought to be beneficial but there is likely to be a delay, alternative forms of hydration must be considered and discussed with the person.
- Decisions about clinically assisted hydration and nutrition must be in line with the **General Medical Council 2010 guidance *Treatment and Care towards the End of Life*** and relevant clinical guidelines
- For all cases nursing and medical records on the assessment of intake must be kept

HYDRATION & NUTRITION: Detail below any specific instructions		
Date/Time	**Notes:**	**Signature/role**

Please Indicate PREFERRED PLACE OF DEATH (PPoD):

Not established (please give reason)	Usual Place of Residence	Hospice	Other (specify)

If the Preferred Place of Death is somewhere other than their current place of care: please indicate within the assessment notes **on page 7** what has been done to facilitate achievement of this preference, and any reasons why achievement of PPoD is not possible**.**

ANTICIPATORY PRESCRIBING

*PLEASE ENSURE THAT ANTICIPATORY MEDICATIONS ARE PRESCRIBED FOR **ALL 5** OF THE MOST COMMONLY EXPERIENCED SYMPTOMS*

Refer to table on Page 4 or to algorithms Pages 21-25 for more guidance

	ease tick when prescribed
PAIN	
AGITATION	
RESPIRATORY TRACT SECRETIONS	
NAUSEA & VOMITING	
BREATHLESSNESS	
Also consider and prescribe for OTHER TREATABLE SYMPTOMS experienced or predictable	

Nursing Assessment & Ongoing Individualised Care Planning

NB: Ongoing Assessments may be completed by any member of the multi-professional team

1. Family/Significant Others Support & Information
2. Ongoing Assessment- Individualised Care Planning
3. Daily Review (where responsibility has been delegated to Nursing staff)
4. Nurse Verification of Expected Death

Assessment and documentation of a person's spirituality has been found both locally and nationally to be one of the most misunderstood and therefore neglected areas of holistic assessment during a person's final days and hours.

The FICA tool below aims to support professionals in their facilitation of an environment of trust by indicating to the person that the healthcare professional is **open to listening** to the person about his or her spiritual issues, **if the patient wants to talk about those issues**.

Healthcare professionals are encouraged not to use the FICA tool as a checklist, but rather to rely on it as a guide to aid and open the discussion to spiritual issues.

FICA Spirituality Assessment Tool © Pukalski

The acronym FICA can help structure questions in taking a spiritual history by healthcare professionals.

F-Faith or beliefs: *What are your spiritual or religious beliefs? Do you consider yourself spiritual or religious? What things do you believe in that give meaning to life? Do you have any beliefs that help you to cope at difficult times?*

I-Importance and influence: *What importance does faith or belief have in your life? How has your illness and/or hospitalisation affected your personal practices /beliefs?*

C-Community: *Are you part of a religious or spiritual community? In what ways do you get support from this community? ? Is there a person/group/leader that supports/assists you in your spirituality? Are there any individual's and/or groups of people that are really important to you?*

A-Address/Action: *How would you like me to address these issues? Is there anything that I can do to support your spiritual beliefs/practices?*

Section 5- Support to Family & Significant Others

IDENTIFY THE SUPPORT NEEDS OF FAMILY/SIGNIFICANT OTHERS

- Address any concerns or information needs expressed by the family/significant others whilst observing patient confidentiality and consent
- Consider referral to other supportive services e.g. Crossroads, Hospice
- Early referral to bereavement services if appropriate
- Spiritual/religious needs (which may differ from those of the dying individual)

If the individual is not being cared for at home:

- Ensure contact numbers updated for key family members
- Explain facilities available e.g. parking permits, folding beds for relatives, open visiting
- Consider side room/ privacy of the environment- enable quality time together

Check that the details of the family/ significant others been updated? ☐

Where applicable enquire about contact during the night/and or day and record below:

……

Date/Time	DETAIL BELOW ANY SPECIFIC INFORMATION OR DISCUSSIONS CONCERNING THE SUPPORT OF FAMILY/SIGNIFICANT OTHERS Notes	Signature/Role

DISCUSSIONS & SUPPORTIVE INFORMATION FOR FAMILY/SIGNIFICANT OTHERS

Have the family/significant others been offered the following supportive information

1. **<u>What to expect during the last days and hours including symptoms e.g. use of a Syringe Driver</u>**

Discussed: Yes No **Leaflet Given**: Yes No Offered but declined

Reason for not discussing/ using leaflet *(where applicable):*……

2. **<u>Facilities available for those visiting a person who is dying?</u>**

Discussed: Yes No NA **Leaflet Given**: Yes No NA Offered but declined

Reason for not discussing/using leaflet *(where applicable):*……

<u>Other supportive information</u> ***(****please detail below****)***

……..

Section 6 – Individualised Care Plan & Daily Nurse Review

Ongoing assessment should take place, wherever possible, within the persons preferred place of death. Assessment of the individual should be carried out holistically, and should consider the needs of both the person and their family/significant others. It should be 'concerns led' and flexible to respond to new circumstances. The following principles should be used to guide the documentation of ongoing assessment. NB This list is not exhaustive.

1. Communication

Ensure compassionate person centred communication with the individual (where possible), and with family and/or significant others

Find out and respond to any concerns, preferences, or information needs-proactive communication

Ensure frequent updates are given to the family and/or significant others concerning the individual's condition

Carefully document the details of any significant conversations with either the individual and/or their family/ significant others

Ensure effective handover of the individuals condition, including any changes in planned care to all relevant staff- document the named nurse at each handover period

Ensure the person receives a daily review by either the senior clinician or those with delegated responsibility as detailed on page 8

2. Symptom Control

Monitor (at least 4hrly in acute hospitals) for common symptoms and administer medication according to individual need, particularly:

Pain
Agitation
Respiratory Tract Secretions
Nausea/vomiting
Dyspnoea

Ensure the safe administration and recording of medications.

Consider non-pharmacological options to manage symptoms

Obtain Specialist Palliative Care Advice where needed

Monitor effectiveness of symptom management interventions

If a syringe driver pump is in situ ensure regular checks are made.

3. Privacy & Dignity

Support the hygiene needs of the individual based upon their comfort

Observe skin integrity and advise and support on appropriate positioning according to comfort

Consider the privacy of the environment e.g. noise levels, use of a side room. Allow quality time between the person and their family members/significant others

4. Hydration & Nutrition

Continue to support oral fluids where tolerated

Continually assess the individual to determine the appropriateness of artificial hydration and/or nutrition

Ensure regular and effective mouth care is given

Offer advice and support to the family/significant others to enable them to participate

Consider the use of thickened fluids

Maintain accurate fluid balance records

5. Spirituality

Enquire about, and respect any cultural or religious-specific requirements that are considered important to the individual and/or to their family/ significant others

Support timely involvement of chaplaincy/ spiritual leaders where this is requested

Consider the non-faith aspects of spirituality e.g. hope, meaning, values, love and trust

6. Elimination

Ensure person is not distressed by urinary retention, incontinence or constipation

Consider catheter, incontinence aids or bowel intervention to relieve distress

7. Other Individualised Care *(please detail below - e.g. tracheostomy care)*

Date/Time/Place	Ongoing Individualised Care Planning notes (The prompts on p14 MUST be used to ensure all domains of care are regularly assessed and well documented)	Signature/Role

DAILY REVIEW (where this has been delegated to nursing staff on page 8)

Delegated Clinician:

Name_____Signature_____Role_____Date/Time_____

Delegated Clinician:

Name_____Signature_____Role_____Date/Time_____

Date/Time/Place	Ongoing Individualised Care Planning notes (The prompts on p14 MUST be used to ensure all domains of care are regularly assessed and well documented)	Signature/Role

DAILY REVIEW (where this has been delegated to nursing staff on page 8)

Delegated Clinician:

Name_____Signature_____Role_____Date/Time_____

Delegated Clinician:

Name_____Signature_____Role_____Date/Time_____

Date/Time/Place	Ongoing Individualised Care Planning notes (The prompts on p14 MUST be used to ensure all domains of care are regularly assessed and well documented)	Signature/Role

DAILY REVIEW (where this has been delegated to nursing staff on page 8)

Delegated Clinician:

Name_____Signature_____Role_____Date/Time_____

Delegated Clinician:

Name_____Signature_____Role_____Date/Time_____

Date/Time/Place	Ongoing Individualised Care Planning notes	Signature/Role

	(The prompts on p14 MUST be used to ensure all domains of care are regularly assessed and well documented)	

DAILY REVIEW (where this has been delegated to nursing staff on page 8)

Delegated Clinician:

Name_____Signature_____Role_____Date/Time_____

Delegated Clinician:

Name_____Signature_____Role_____Date/Time_____

Section 7: After Death/ Nurse Verification of Expected Death

Verification of death

NB: BEFORE PROCEEDING ENSURE THERE ARE NO CAUSES FOR CONCERN REGARDING THE CIRCUMSTANCES OF DEATH *(follow local policy for procedures whereby concerns are raised)*

Date of death ..... Time of death .....

Persons present at time of death & relationship to the deceased.....

.....

Notes/Comments .....

If not present, has the individual's relative or significant other been informed?

Name of relative informed: …… Yes ☐ No ☐ No relative/carer ☐

Name of professional verifying death ..... **Signature** …….....

Role ..... Date/ Time of verifying .....

Is discussion with, or review by, the coroner required **Yes** ☐ **No** ☐

If a Doctor has agreed to Nurse Verification of expected death (see page 9) and a trained nurse is verifying death, this section needs to be completed by the nurse (as per the NVoED policy).

The overall duration of the assessment of cardiac and respiratory function must be **at least 5 minutes**. Any spontaneous return of cardiac or respiratory activity should prompt another 5 minutes of checks.

Vital signs checked:

• Carotid pulse absent on palpation	**Yes** ☐ **No** ☐
• Heart sounds absent on auscultation	**Yes** ☐ **No** ☐
• Respirations absent for one minute	**Yes** ☐ **No** ☐
AFTER 5 minutes of continued cardiorespiratory arrest the following checks should be made:	
• Absence of pupillary response to light and corneal reflexes	**Yes** ☐ **No** ☐
• No motor response to painful stimuli (trapezius muscle squeeze)	**Yes** ☐ **No** ☐

Care after death notes: record relevant issues/communications (including feedback from relatives)

Date		**Name** *(print),* **signature & role**

Name: Date of Birth: NHS No:

Communication & support after death		***Signature/date***
Care & Dignity	**Initial care after death is undertaken in accordance with policy** Consider: • Spiritual, religious, cultural rituals/needs met • The facilitation of quality time with the deceased as appropriate for the care setting and to meet the needs of the family/ significant others • Individual is treated with respect & dignity if any care is provided after death • If CSCI/Syringe Driver in use, following verification of death, it is removed & drug contents disposed of in accordance with policy.	
Relative /Carer/ Information	**The relative/carer understands what is required to do next & given relevant written information** Consider relative/carer information needs relating to the next steps, where appropriate: • Contacting a funeral director, how a death certificate will be issued, registering the death • Acting on patient's wishes regarding tissue/organ donation • Discuss as appropriate, the need for a post mortem, or removal of cardiac devices or when discussion with the coroner required • Bereavement support/services, including child bereavement services • Disposal of drugs & equipment • Provision of supportive leaflet/booklets: • Local bereavement booklet/services contacts/other bereavement information • DWP1027 (England & Wales) 'What to do after a death' booklet or equivalent	
Organisation Information	**The Primary Care Team/ GP Practice is notified of the patient's death**	Enter date/time of notification:

Other services involved notified of patient's death

Out of hour services (i.e. GPs, Nursing, other services)	Yes ☐ No ☐ N/A ☐
Hospice	Yes ☐ No ☐ N/A ☐
Macmillan Nurses	Yes ☐ No ☐ N/A ☐
Other Specialist Nurse	Yes ☐ No ☐ N/A ☐
Hospital	Yes ☐ No ☐ N/A ☐
Out Patient Services e.g. Chemotherapy, endoscopy	Yes ☐ No ☐ N/A ☐
Community Matron	Yes ☐ No ☐ N/A ☐
Allied Health Professionals (i.e. Physio, OT, Dietician)	Yes ☐ No ☐ N/A ☐
Social Services	Yes ☐ No ☐ N/A ☐
Continuing Health	Yes ☐ No ☐ N/A ☐
Other care agencies (i.e. Crossroads, Marie Curie)	Yes ☐ No ☐ N/A ☐
Continence	Yes ☐ No ☐ N/A ☐
Hospital Care at Home	Yes ☐ No ☐ N/A ☐
Community equipment	Yes ☐ No ☐ N/A ☐
Other, please state .....……	Yes ☐ No ☐ N/A ☐

When this section is complete. Healthcare professional name *(print)* .....

Signature …… **Role** ..... **Date** .....

Name: Date of Birth: NHS No:

PAIN

(In end of life patients unable to take oral medication)

Patient is IN PAIN

Patient HAS been receiving an OPIOID (INCLUDING "WHEN REQUIRED" DOSES)

<u>Prescribe regular 24hr Dose in Syringe Pump</u>
ADD TOGETHER both regular and "when required" opioid doses given in the past 24 hours and CONVERT to the equivalent dose of SC morphine*.

If patient is wearing an <u>opioid patch</u>, do NOT remove this. ADD TOGETHER the "when required" opioid doses given in the past 24hours and convert this to the equivalent dose of SC morphine*. SEE WORKED EXAMPLE

Consider increasing the regular dose prescribed up to 30-50% if patient is unstable and needs additional opioid

<u>Prescribe "when required" dose</u>
Divide the NEW total regular dose in 24 hours by 6 and prescribe 2hourly SC "when required".

If patient is on a patch, include this in calculation of the total regular dose.

Give the "when required" dose of SC morphine* stat for pain.

Patient has NOT been receiving an OPIOID

<u>Prescribe "when required" dose</u>
Prescribe 2.5mg-5mg morphine*
2hourly SC "when required".

Give the "when required" dose of SC morphine* stat for pain.

<u>Note:</u>
* This chart is for morphine: an alternative opioid may be used.
The same principles regarding use apply for other opioids. Use conversion charts to calculate the appropriate dose.

Patient is NOT in PAIN

Patient HAS been receiving an OPIOID (INCLUDING "WHEN REQUIRED" DOSES)

<u>Prescribe regular 24hr Dose in Syringe Pump</u>
ADD TOGETHER both regular and "when required" opioid doses given in the past 24hours and CONVERT to the equivalent dose of SC morphine*.

If patient is wearing an <u>opioid patch</u>, do NOT remove this. ADD TOGETHER the *"when required"* opioid doses given in the past 24hours and CONVERT this to the equivalent dose of SC morphine*.

<u>Ensure a suitable "when required" opioid dose is prescribed</u>
Divide the NEW total regular dose in 24 hours by 6 and prescribe 2hourly SC "when required". If patient is on a patch, include this in your calculation of the total regular dose

Patient has NOT been receiving an OPIOID

<u>Prescribe "when required" dose</u>
Prescribe 2.5mg-5mg morphine*
2 hourly SC "when required"

WORKED EXAMPLE
Patient wearing a fentanyl 25mcg/hr patch - equivalent to 30mg of SC morphine/24hrs. Patient also prescribed 10mg morphine orally "when required" and had 3 doses in the past 24hrs. 30mg of oral morphine is equivalent to 15mg SC morphine/24hrs.

Do not stop fentanyl patch and continue to reapply at the same dose. To account for "when required" doses, prescribe a syringe pump with 15mg of morphine SC over 24 hours (the total prn doses received) in addition to the patch.

To calculate the NEW "when required" dose, add the equivalent amount of SC morphine in the patch and the amount syringe pump together to give a total of 45mg SC morphine. Divide this total amount by 6 to give 7.5mg SC morphine as the "when required" dose.

Review pain and use of "when required" doses daily. If 2 or more "when required" doses have been needed over 24hours, add the total amount given to the regular dose in the 24hour SC syringe pump and re-calculate the new "when required" dose. It is usually recommended to increase the regular dose by 30-50%. Caution should be exercised in increasing beyond this. Seek specialist advice as needed.

Name…… Date of Birth ……. NHS No……..

BREATHLESSNESS

(In end of life patients unable to take oral medication)

Patient is BREATHLESS

Patient HAS been receiving an OPIOID (INCLUDING "WHEN REQUIRED" DOSES)

<u>Prescribe regular 24hr Dose in Syringe Pump</u>

ADD TOGETHER both regular and "when required" opioid doses given in the past 24hours and CONVERT to the equivalent dose of SC morphine*.

If patient is wearing an <u>opioid patch</u>, do NOT remove this. ADD TOGETHER the "when required" opioid doses given in the past 24hours and CONVERT this to the equivalent dose of SC morphine*.

Consider increasing the regular dose prescribed up to 30-50% if patient is unstable and needs additional opioid.

<u>Prescribe "when required" dose</u>

Divide the NEW total regular dose in 24 hours by 6 and prescribe 2hourly SC "when required".

If patient is on a patch, include this in calculation of the regular dose. See WORKED EXAMPLE on pain algorithm.

As patient is breathless give the "when required" dose of SC morphine* stat.

Patient has NOT been receiving an OPIOID

<u>Prescribe "when required" dose</u>

Prescribe 2.5mg-5mg morphine* 2hourly SC "when required"

As patient is breathless give the "when required" dose of SC morphine* stat.

Patient is NOT BREATHLESS

Patient HAS been receiving an OPIOID (INCLUDING "WHEN REQUIRED" DOSES)

<u>Prescribe regular 24hr Dose in Syringe Pump</u>

ADD TOGETHER both regular and "when required" opioid doses given in the past 24hours and CONVERT to the equivalent dose of SC morphine*.

If patient is wearing an <u>opioid patch</u>, do NOT remove this. ADD TOGETHER the *"when required"* opioid doses given in the past 24hours and CONVERT this to the equivalent dose of SC morphine*.

<u>Ensure a suitable "when required" opioid dose is prescribed</u>

Divide the NEW total regular dose in 24 hours by 6 and prescribe 2hourly SC "when required". If patient is on a patch, include this in your calculation of the total regular dose.

Patient has NOT been receiving an OPIOID

<u>Prescribe "when required" dose</u>

Prescribe 2.5mg-5mg morphine* 2hourly SC "when required"

Review breathlessness and use of "when required" doses daily. If 2 or more "when required" doses have been needed over 24hours, add the total amount given to the regular dose in the 24hour SC syringe pump and re-calculate the new "when required" dose. It is usually recommended to increase the regular dose by 30-50%. Caution should be exercised in increasing beyond this. If breathlessness is not responding to increasing doses of opioid, seek specialist advice.

<u>Notes:</u>

- This chart is for morphine: an alternative opioid may be used. The same principles regarding use apply for other opioids. Use conversion charts to calculate the appropriate dose
- Treatments for reversible causes include: bronchodilators, diuretics, and antibiotics
- Simple measures such as a calm environment, a fan or open window can be just as effective as medication
- If patient remains breathless despite opioid, consider midazolam 2.5-5mg 2hourly "when required". If effective, this can be incorporated into a 24hr SC syringe pump.

EXCESSIVE RESPIRATORY TRACT SECRETIONS

(In end of life patients unable to take oral medication)

Patient has EXCESSIVE RESPIRATORY TRACT SECRETIONS

Prescribe 200micrograms glycopyrronium SC 3 hourly "when required" (max 1200micrograms/24hours) and give a STAT dose to the patient.

<u>If symptoms persist start syringe pump</u>
If requiring 2 or more "when required" doses/24hrs, prescribe 600micrograms glycopyrronium via 24hour SC syringe pump

<u>If symptoms persist</u>
If requiring 2 or more "when required" doses/24hrs, increase syringe pump up to a maximum dose of 1200micrograms glycopyrronium via 24hour SC syringe pump.

IF THE PATIENT'S RESPIRATORY TRACT SECRETIONS ARE STILL A PROBLEM AT MAXIMUM DOSE, SEEK SPECIALIST ADVICE

Patient does NOT have EXCESSIVE RESPIRATORY TRACT SECRETIONS

<u>Prescribe anticipatory "when required" dose</u>
Prescribe 200micrograms glycopyrronium SC 3 hourly "when required" (max 1200micrograms/24hours)

<u>Notes:</u>

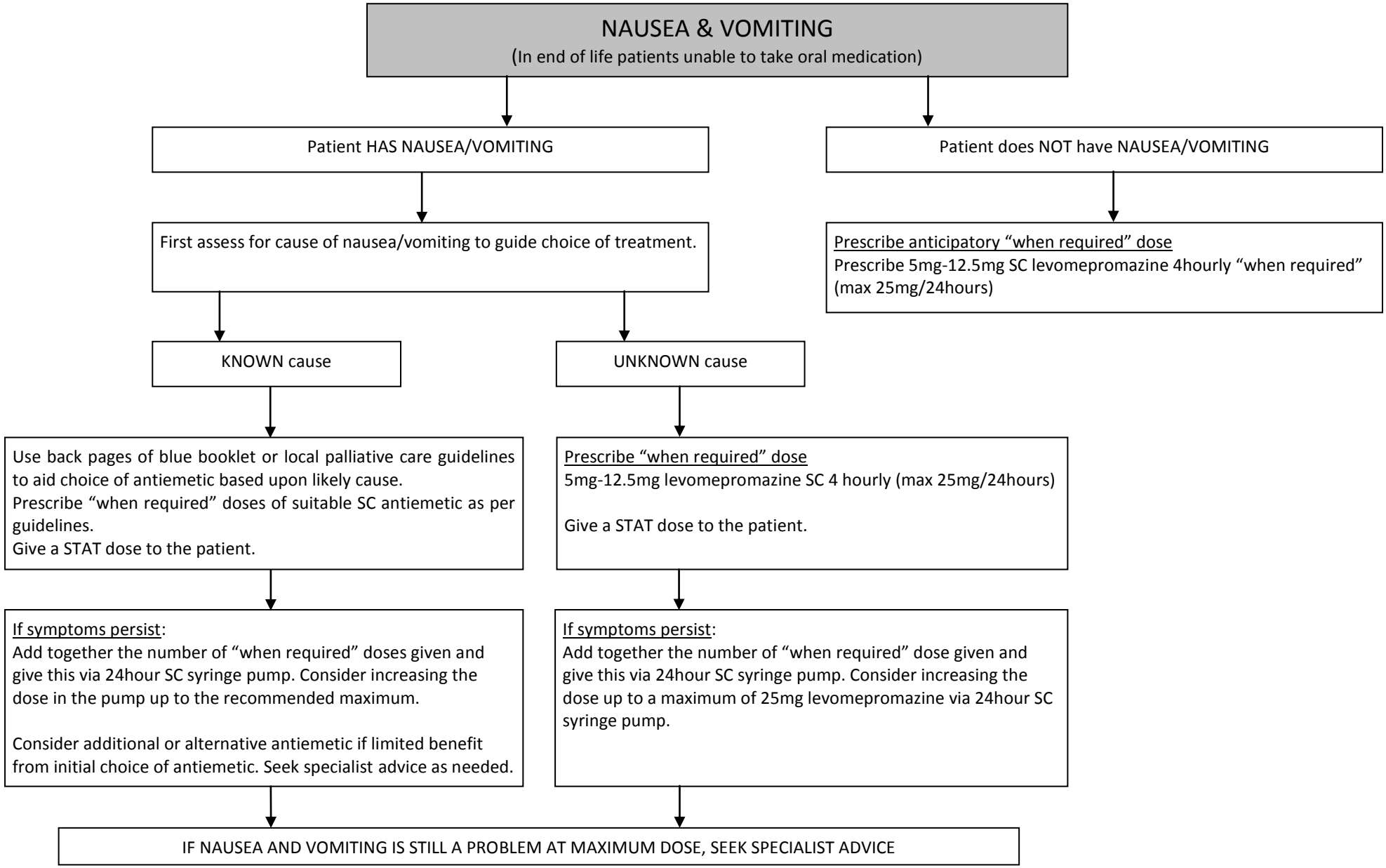
- These medicines will not clear existing secretions. Start when symptoms first appear.
- Treatment is only effective in 50-60% of patients – more likely to be effective if secretions are due to unswallowed saliva.
- Many relatives are satisfied by explanation alone.
- A conscious patient treated with these drugs will be aware of an uncomfortably dry mouth.

<u>Hyoscine butylbromide may be used as an alternative</u>

<u>"When required" dose</u>
Prescribe 20mg hyoscine butylbromide SC 3hourly "when required" (max 120mg/24hours)

<u>Regular dose</u>
If requiring 2 or more "when required" doses/24hrs start 60mg hyoscine butylbromide via 24hour SC syringe pump. Can increase up to a maximum of 120mg 24hours.

Name…… Date of Birth ……. NHS No……..



Name…… Date of Birth ……. NHS No……..

RESTLESSNESS & AGITATION

(In end of life patients unable to take oral medication)

Patient IS RESTLESS/AGITATED

<u>Prescribe "when required" dose</u>
Prescribe 2.5mg-5mg midazolam SC 2hourly "when required" (max 60mg/24hours).

Give a STAT dose to the patient.

<u>If requiring two or more doses in 24 hours or unsettled</u>
Prescribe 10mg midazolam via 24hour SC syringe pump.

Also give a STAT dose for the patient.

<u>If symptoms persist</u>
Add together the number of "when required" doses given and increase dose incrementally to a maximum dose of 60mg midazolam via 24hour SC syringe pump.

Also consider increasing stat dose incrementally up to a maximum of 10mg.

Consider prescribing **levomepromazine** 12.5mg-25mg SC 4hourly "when required" and add dose given in previous 24hours to a syringe pump if effective.

Patient is NOT RESTLESS/AGITATED

<u>Prescribe "when required" dose</u>
Prescribe 2.5mg-5mg midazolam SC 2hourly "when required" (max 60mg/24hours)

<u>Note:</u>
Be aware of the risk of paradoxical agitation with midazolam. This is more common at higher doses. Seek specialist advice.