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 01270 612266 **Extension 2266** **Bleep 2266/2723**	**St Luke's Hospice Helpline (24 hour advice available) Tel 01606 555489** **#6530**

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 – Leighton Hospital via switchboard

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**.**

<u>Page 6 should be used as a prompt</u> 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**

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

*PLEASE ENSURE THAT ANTICI–PATORY MEDICATIONS ARE PRESCRIBED FOR

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

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

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

2. **Facilities available for those visiting a person who is dying?**

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

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

Other supportive information ***(****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 (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_____

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**

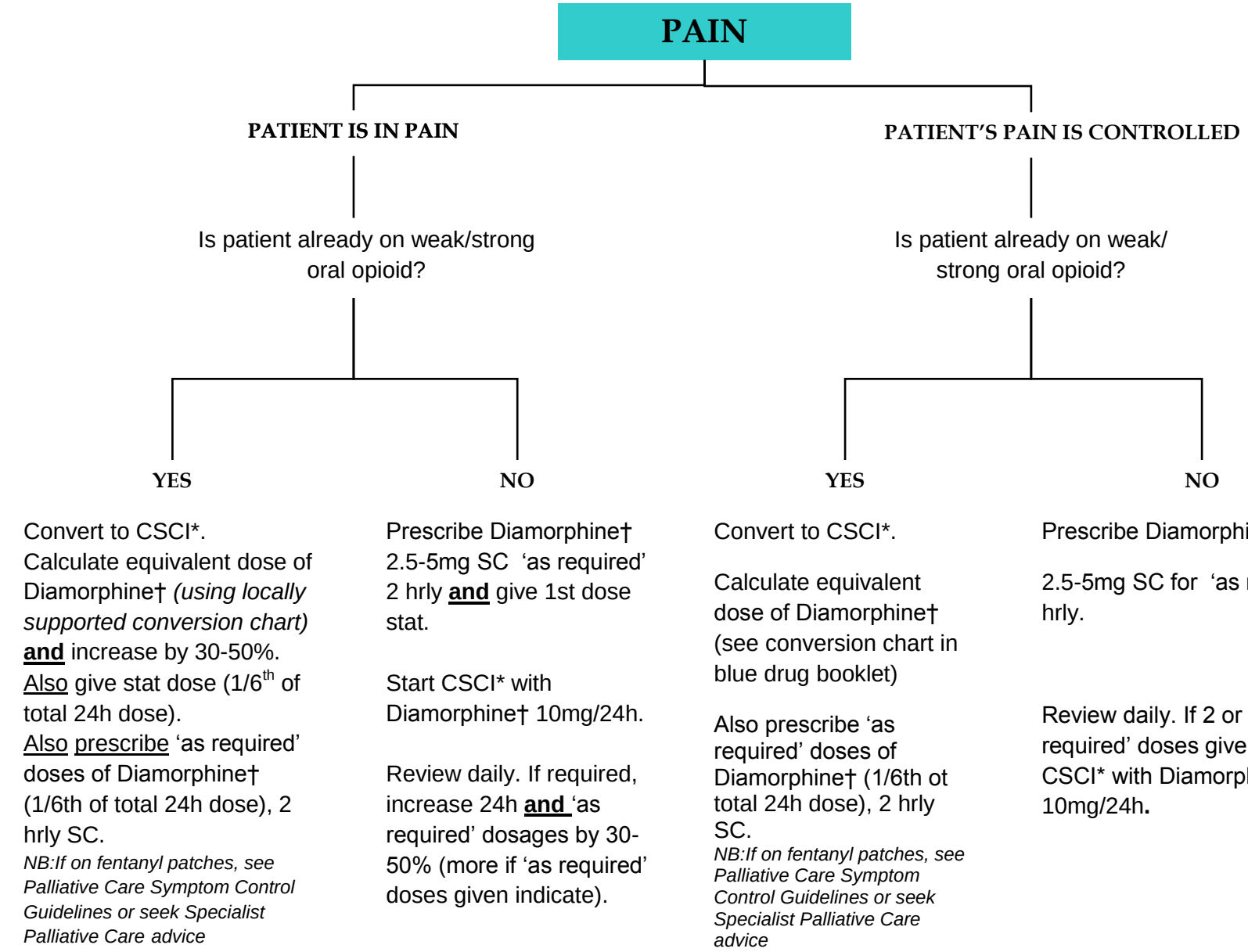
Communication & support after death		***Signature/date***
Care & Dignity	**Initial care after death is undertaken in accordance with policy** Consider: • Spiritual, religious, cultural rituals/needs met • The facilitation of quality time with the deceased as appropriate for the care setting and to meet 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** .....



If symptoms persist or further advice required contact the Specialist Palliative care team or local Hospice – see front of Care Plan for contact details.

†- if Diamorphine not available, use equivalent dose of Morphine Sulphate for injection.

*CSCI – continuous subcutaneous infusion via syringe driver

BREATHLESSNESS

PRESENT

Is patient already on weak/strong oral opioid?

YES

Convert to CSCI*.
Calculate equivalent dose of Diamorphine† (see conversion chart in blue drug booklet) and increase by 30-50%.
Also prescribe 'as required' doses of Diamorphine† (1/6th of total 24h dose), SC, 2 hrly.
If distress of symptom persists, consider adding Midazolam by CSCI* 10-20mg/24h.

NO

Prescribe 'as required' Diamorphine† 2.5-5mg SC 2 hrly.
and/or 'as required' Midazolam 2.5-5mg SC or buccal, 3 hrly.

Review daily. If 2 or more 'as required' doses given, consider CSCI* starting with either

Diamorphine† 10mg/24h

Midazolam10mg/24h

ABSENT

Is patient already on weak/ strong oral opioid?

NO

Prescribe 'as required' Diamorphine† 2.5-5mg SC ,2 hrly.

and/ or 'as required' Midazolam

2.5-5mg SC or buccal, 3 hrly.

Review daily. If 2 or more 'as required' doses given, consider CSCI* starting with either

- Diamorphine† 10mg/24h *or*
- Midazolam10mg'24h

If symptoms persist or further advice required contact the Specialist Palliative care team or local Hospice – see front of Care Plan for contact

†- if Diamorphine not available, use equivalent dose of Morphine Sulphate for injection. *CSCI – continuous subcutaneous infusion via syringe driver

MOIST NOISY BREATHING/RESPIRATORY TRACT SECRETIONS

PRESENT

Prescribe stat dose of Glycopyronnium, 200 micrograms SC, repeated after 30mins if necessary

Prescribe 'as required' doses of Glycopyronnium 200 micrograms SC, 3 hrly (max 1200 micrograms/24h†)

Or

Prescribe stat dose of Hyoscine Butylbromide (buscopan) 20mgs, SC.

Prescribe 'as required' doses of Hyoscine Butylbromide 20mgs SC, 3 hrly (max 120mgs/24h†).

ABSENT

Prescribe 'as required' doses of Glycopyronnium 200 micrograms SC, 3 hrly (max 1200 micrograms/24h†)

Or

Prescribe 'as required' doses of Hyoscine Butylbromide 20mgs SC, 3 hrly (max 120mgs/24h†).

If 2 or more doses of 'as required' are needed
consider use of CSCI*
Glycopyrronium 1200micrograms/24h by CSCI*
Or
Hyoscine Butylbromide 60-120mgs/24h by CSCI*

Note:

- Drugs will not clear existing secretions.
- Treatment effective in 50-60% - more likely if noisy secretions due to unswallowed saliva, less likely if respiratory tract secretions.
- Many carers satisfied by explanation alone.
- A conscious patient treated with these drugs will be aware of an uncomfortably dry mouth

If symptoms persist or further advice required contact the Specialist Palliative Care Team or local Hospice – see front of Care Plan for contact details.

*CSCI – continuous subcutaneous infusion via syringe driver

† - maximum 24 hr dose. Seek specialist palliative advice for further information if symptoms persist

NAUSEA & VOMITING

PRESENT

Give Cyclizine 50mgs SC as stat dose **and** start Cyclizine 100-150mgs/24h by CSCI*

Or

Give Haloperidol 1.5-5mgs as stat dose **and** start Haloperidol 2.5-10mgs/24h by CSCI*

Prescribe 'as required' doses:

Cyclizine – 50mgs SC, 4-6 hrly (max 200mgs/24h†)

Haloperidol – 1.5-5mgs SC, 4-6 hrly (max 15mgs/24h†)

If symptoms persist, see box below

If symptoms persist

Cyclizine and Haloperidol can be used together by CSCI*.

Or

Convert to Levomepromazine, 6.25-25mgs/24h by CSCI*

Prescribe 'as required' Levomepromazine 6.25-12.5mgs SC, 4-6hrly (max 25mgs/24h†)

ABSENT

Prescribe Cyclizine 50mgs SC, 4-6 hrly (max200mgs/24h†) 'as required'

Or

Haloperidol 1.5-5mgs SC, 4-6 hrly (max 10mgs24h /†) 'as required'.

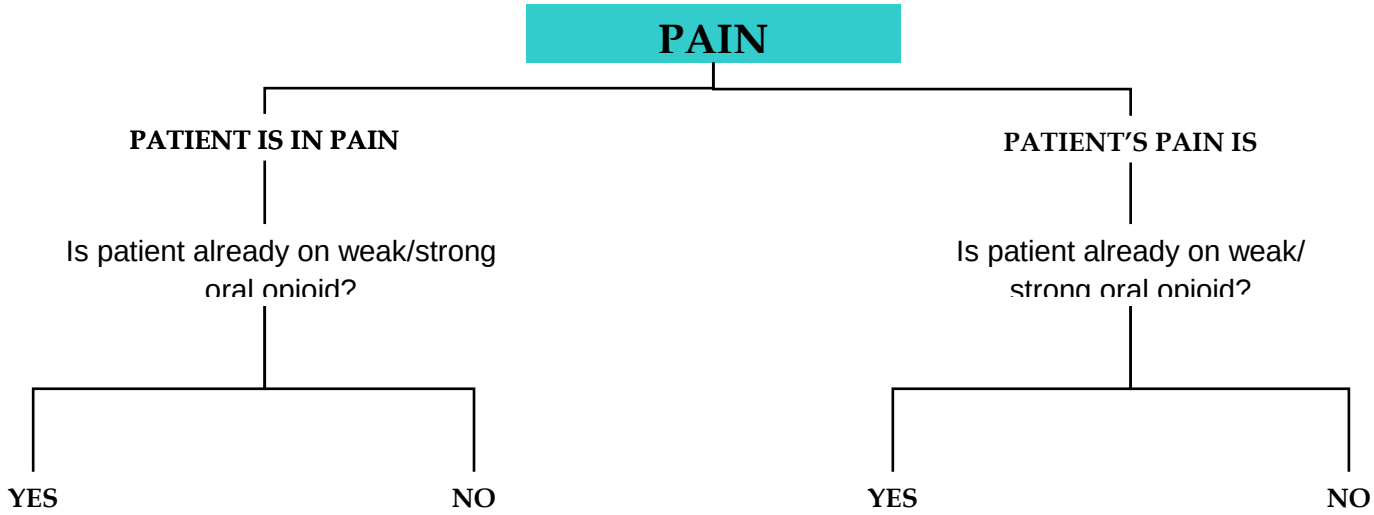
Review daily. If 2 or more 'as required' doses given, consider converting to CSCI*

If symptoms persist, further advice required or patient has bowel obstruction, contact the Specialist Palliative care team or local Hospice – see front of Care Plan for contact details.

*CSCI – continuous subcutaneous infusion via syringe driver.

† - maximums given as a guide. Seek Specialist palliative advice for further information if symptoms persist

Name…… Date of Birth ……. NHS No……..



Convert to CSCI*.
Calculate equivalent dose of Diamorphine† (see conversion chart in blue drug booklet)
and increase by 30-50%.
Also give stat dose (1/6th of total 24h dose).

Also prescribe 'as required' doses of Diamorphine† (1/6th of total 24h dose), 2 hrly SC.

Prescribe Diamorphine† 2.5-5mg SC for 'as required' 2 hrly **and** give 1st dose stat.

Start CSCI* with Diamorphine† 10mg/24h.

Review daily. If required, increase 24h **and** 'as required' dosages by 30-50% (more if 'as required'

Convert to CSCI*.

Calculate equivalent dose of Diamorphine† (see conversion chart in blue drug booklet)

Also prescribe 'as required' doses of Diamorphine† (1/6th ot total 24h dose), 2 hrly SC.

Prescribe Diamorphine†

2.5-5mg SC for 'as required' 2 hrly.

Review daily. If 2 or more 'as required' doses given, consider CSCI* with Diamorphine†

If symptoms persist or further advice required contact the Specialist Palliative care team or local Hospice – see front of Care Plan for contact details.
†- if Diamorphine not available, use equivalent dose of Morphine Sulphate for injection.
*CSCI – continuous subcutaneous infusion via syringe driver

RESTLESSNESS & AGITATION

PRESENT

Prescribe Midazolam 2.5-5mg SC stat dose, repeated after 30 mins if necessary
And prescribe Midazolam 10-20mg/24h by CSCI*
Prescribe 'as required' doses of Midazolam 2.5-10mg SC, 3 hrly (max 60mg/24h †)

ABSENT

Prescribe 'as required' doses of Midazolam 2.5-10mg SC, 3 hrly (max 60mg/24h †)

Review daily. If 2 or more 'as required' doses given, consider converting to CSCI*

If symptoms persist

Prescribe Levomepromazine 12.5-25mg SC to give as a stat dose and for 'as required' doses, 3 hrly.(max 150mg/24h†).

If effective, consider adding Levomepromazine 25-50mg\24h to the Midazolam in the CSCI*.

If symptoms persist or further advice required contact the Specialist Palliative care team or local Hospice – see front of Care Plan for contact details.

*CSCI – continuous subcutaneous infusion via syringe driver.
† - maximums given as a guide. Seek Specialist palliative advice for further information if symptoms persist

Guideline for Continued Use of Transdermal Fentanyl in Dying Patients

When a person is no longer able to take oral breakthrough medication the fentanyl patch should continue to be changed every 72 hours as was prescribed unless there are toxic opioid side effects.

A subcutaneous opioid should be prescribed, to be given if the person experiences breakthrough pain.

Table: Breakthrough doses of subcutaneous Diamorphine and Morphine for patients on Transdermal Fentanyl

Transdermal Fentanyl patch (**micrograms** per hour)/72hours	4 hourly dose of **Diamorphine** subcutaneously (**mg**)[1,2,3]	4 hourly dose of **Morphine** subcutaneously (**mg**)[2,3]
25	2.5 - 5	5
50	5 - 7.5	10
75	10	15
100	15	20
150	20	30
200	25	40
300	40	60†

† consider as 2 separate injections as large volume will likely cause discomfort for patient

Conversion charts and calculations are approximate, giving guidance only, and some sources may differ. If in doubt then calculate on the cautious side if the risk of side effects outweighs the intended benefit, whilst ensuring the patient has adequate breakthrough medication prescribed and available. For specialist advice and support contact your local hospice (contact numbers available at the front of this care plan).

If a patient requires two or more doses of an opioid for breakthrough pain over a 24 hour period, consider commencing a continuous subcutaneous infusion of diamorphine/morphine in a syringe driver over 24 hours **in addition to continuation of their fentanyl patch** as prescribed.

If the addition of a syringe driver is made, the breakthrough dose of opiate needs to be amended, taking into account both the opioid in the fentanyl patch, and the opioid in the syringe driver.

Example

A patient is using a 200microgram/hour fentanyl patch. The prescriber wants to use diamorphine for breakthrough pain. The breakthrough dose of diamorphine can be seen from the table above, and would be 25mg. If the patient required three doses of 25mg diamorphine in the last 24 hours this 75mg could be added to a syringe driver and given **in addition to the fentanyl patch**.

A new breakthrough dose will now need to be calculated to take into account the total opioid dose the patient is receiving per 24 hours. This can be calculated as below:

1. Calculate the dose of diamorphine which the fentanyl 200microgram/hour patch would be equivalent to per 24 hours. This can be done by multiplying the 4 hourly breakthrough dose for their 200microgram/hour patch (25mg diamorphine) by 6 = 150mg diamorphine/24hours
2. Add the syringe driver dose of diamorphine/24 hours to this figure = 150mg+75mg=225mg total diamorphine equivalent dose over 24 hours
3. Divide the total diamorphine equivalent dose over 24 hours (i.e. 225mg) by 6 to give the new breakthrough dose of diamorphine = 225mg÷6=37.5mg (round dose to the nearest 5mg)

Regular and breakthrough dose requirements need to be reassessed at least every 24 hours.

If a fentanyl patch needs to be discontinued, note that fentanyl plasma levels fall gradually due to continued absorption from the skin. Plasma fentanyl concentrations reduce by approximately 50% in 17 hours (range 12-24 hours).

If possible, it is advisable to use subcutaneous opioid ‘stat’ injections for the initial 24 hours while the fentanyl plasma level is falling and start the syringe driver after 24 hours.

Note: For further support or advice contact your Specialist Palliative Care Team – contact details as per front sheet

References

1. *MCHFT Controlled Drugs Policy V3.2*
2. *Twycross R, Wilcock A. Palliative Care Formulary, fourth edition 2011*
3. *British National Formulary (BNF) Online edition used www.bnf.org accessed June 2014*
4. *Merseyside and Cheshire Standards and Guidelines fourth edition 2010*
5. *Greater Manchester and Cheshire Symptom Control Guidelines 2011*
6. *COMPATIBILITY CHARTS available at:*
    a. *MCHFT Controlled Drugs Policy V3.2*
    b. *British National Formulary*
    c. *Contact Medicines Information on extension: 2267*