LIVERPOOL Care Pathway
Promoting best practice for care of the dying

NHS Lanarkshire

Liverpool Care Pathway

(Care Home Version)

Patient Name: .... CHI No: .... DOB: ....

GP .... District Nurse ....

Out of Hours Nurse Base	Telephone ....
Macmillan Nurse	Telephone ....
24hr Palliative Care Advice Line	St Andrew's Hospice 01236766951

Instructions for use

1. All goals are in **heavy** typeface. Interventions, which act as prompts to support the goals, are in normal type.
2. The palliative care guidelines are printed on the pages at the end of the pathway. Please make reference as necessary.
3. If you have any problems regarding the pathway contact the LCP Team at St Andrew's Hospice.

The LCP aims to support but does not replace clinical judgment; practitioners are free to exercise their own professional judgment. However, any alteration to the practice identified within this LCP must be noted on the variance sheet.

Criteria for use of the LCP
Refer to algorithm found in resource folder / treatment areas.

All possible reversible causes for current condition have been considered:

The multiprofessional team has agreed that the patient is dying, and two of the following may apply: -

The patient is bed bound ☐ Semi-comatose ☐

Only able to take sips of fluids ☐ No longer able to take tablets ☐

Doctor's Signature ....Date...Time ....

Nurse's / Senior Carer's Signature ....Date ....Time.........................

All personnel completing the care pathway please sign below

Name (print)	*Full signature*	*Initials*	*Professional title*	*Date*

Name: ……………………………………………CHI no:…………………………….Date/Time commenced: ……………………

Section 1	Initial assessment A = Achieved V = Variance If you chart "V" against any goal, please complete variance sheet
Diagnosis & Demographics	**PRIMARY DIAGNOSIS:**…………………………………………… …… **SECONDARY DIAGNOSIS**: …………………………………………… DOB:………………………………… Female ☐ Male ☐ Ethnicity:………………………………………………………
Physical condition ***Act to palliate any current symptoms / problems***	Unable to swallow **Yes** ☐ **No** ☐ Aware **Yes** ☐ **No** ☐ Nausea **Yes** ☐ **No** ☐ Conscious **Yes** ☐ **No** ☐ Vomiting **Yes** ☐ **No** ☐ UTI problems **Yes** ☐ **No** ☐ Constipated **Yes** ☐ **No** ☐ Catheterised **Yes** ☐ **No** ☐ Confused **Yes** ☐ **No** ☐ Respiratory tract secretions **Yes** ☐ **No** ☐ Agitation **Yes** ☐ **No** ☐ Dyspnoea **Yes** ☐ **No** ☐ Restless **Yes** ☐ **No** ☐ Pain **Yes** ☐ **No** ☐ Distressed **Yes** ☐ **No** ☐ Other (e.g. oedema, itch) **Yes** ☐ **No** ☐
Comfort measures	**Goal 1: Current medication assessed and non essentials discontinued** **A** ☐ **V** ☐ Appropriate oral drugs converted to subcutaneous route and syringe driver commenced if appropriate. Inappropriate medication discontinued.
	Goal 2: PRN subcutaneous medication written up for list below as per protocol (See sheets at back of LCP for guidance) Pain Analgesia **A** ☐ **V** ☐ Agitation Sedative **A** ☐ **V** ☐ Respiratory tract secretions Anticholinergic **A** ☐ **V** ☐ Nausea & vomiting Anti-emetic **A** ☐ **V** ☐ Dyspnoea Anxiolytic / Muscle relaxant **A** ☐ **V** ☐
	Goal 3: Discontinue inappropriate interventions Blood test (including BM monitoring) **A**☐ **V**☐ **N/A** ☐ Antibiotics **A** ☐ **V** ☐ **N/A** ☐ I.V.'s (fluids/medications) **A** ☐ **V** ☐ **N/A** ☐ Artificial hydration / nutrition **A** ☐ **V** ☐ **N/A** ☐ Not for cardiopulmonary resuscitation recorded **A** ☐ **V** ☐ (Please record below & complete appropriate associated documentation - policy/procedure) **Deactivate cardiac defibrillators (ICD's)** **Yes** ☐ **No** ☐ **N/A** ☐ Contact patient's Cardiologist Refer to local policy and procedures Information leaflet given to patient / carer if appropriate **Doctor's signature:** ………………………………………… **Date** ………………………………………… **Time** …………..
	Goal 3a: Decisions to discontinue inappropriate nursing interventions taken **Yes** ☐ **No** ☐ Routine turning regime – reposition for comfort only – consider pressure relieving mattress – & appropriate assessments re skin integrity - taking vital signs. If BM monitoring in place reduce frequency as appropriate e.g. once daily
	Goal 3b: McKinley Pump set up within 4 hours of doctors order **Yes** ☐ **No** ☐ **N/A** ☐ **Nurse / Senior Carer signature**: ………………………… … …**Date**:……………………… **Time**:…………..

Name: .... CHI no: .... Date: ....

Section 1	Initial assessment - Continued A = Achieved V = Variance If you chart "V" against any goal, please complete variance sheet
Psychological/ insight	**Goal 4: Ability to communicate in English assessed as adequate** a) Patient **A** ☐ **V** ☐ **Comatose** ☐ b) Family/other **A** ☐ **V** ☐
Record significant discussions in multidisciplinary notes page	**Goal 5: Insight into condition assessed** Aware of diagnosis a) Patient **A** ☐ **V** ☐ **Comatose** ☐ b) Family/other **A** ☐ **V** ☐ Recognition of dying c) Patient **A** ☐ **V** ☐ **Comatose** ☐ d) Family/other **A** ☐ **V** ☐
Religious/ Spiritual support	**Goal 6: Religious/spiritual needs assessed** a) with Patient **A** ☐ **V** ☐ **Comatose** ☐ b) with Family/other **A** ☐ **V** ☐ Patient/other may be anxious for self/others Consider specific cultural needs Consider support of Chaplaincy Team Religious Tradition identified, if yes specify: .... **A** ☐ **V** ☐ **N/A** ☐ Support of Chaplaincy Team offered **A** ☐ **V** ☐ In-house support Tel/bleep no: ....Name: .... Date/time: .... External support Tel/bleep no: ....Name: .... Date/time: .... Comments (Special needs now, at time of impending death, at death & after death identified) ....
Communication with family/other	**Goal 7: Identify how family/other are to be informed of patient's impending death** **A** ☐ **V** ☐ At any time ☐ Not at night-time ☐ Stay overnight at Hospital ☐ Primary contact name: .... Relationship to patient: .... Tel no: .... Secondary contact: .... Tel no: ....
	Goal 8: Family/other given care home information on:- **A** ☐ **V** ☐ Facilities leaflet available to address: Car parking; Accommodation; Beverage facilities; Payphones; Washrooms & toilet facilities on the ward; Visiting times; Any other relevant information.
Communication with primary health care team	**Goal 9: G.P. Practice is aware of patient's condition** **A** ☐ **V** ☐ G.P. Practice to be contacted if unaware patient is dying **9a Out of Hours Service aware of patient's condition** A ☐ V ☐
Summary	**Goal 10: Plan of care explained & discussed with:** a) Patient **A** ☐ **V** ☐ **Comatose** ☐ b) Family/other **A** ☐ **V** ☐
Record significant discussions in multidisciplinary notes page	**Goal 11: Family/other express understanding of planned care** **A** ☐ **V** ☐ Family/other aware that the planned care is now focused on care of the dying & their concerns are identified & documented. The LCP document may be discussed as appropriate

Nurse/ Senior Carer's Signature : .... **Date**: .... **Time:** ....

Name: .... CHI no: .... Date: ....

Codes (please enter in columns) A= Achieved V=Variance (not a signature)
If you chart "V" against any goal, please complete variance sheet
If patient not symptom free, carry out appropriate intervention and reassess in 30 minutes

Section 2 *Patient problem/focus*	*04:00*	*08:00*	*12:00*	*16:00*	*20:00*	*24:00*
Ongoing assessment ***Pain*** **Goal: Patient is pain free** • Verbalised by patient if conscious • Pain free on movement • Appears peaceful • Consider need for positional change						
Agitation **Goal: Patient is not agitated** • Patient does not display signs of delirium, terminal anguish, restlessness (thrashing, plucking, twitching) • Exclude retention of urine as cause • Consider need for positional change						
Respiratory tract secretions **Goal: Excessive secretions are not a problem** • Medication to be given as soon as symptoms arise • Consider need for positional change • Symptom discussed with family/other						
Nausea & vomiting **Goal: Patient does not feel nauseous or vomits** • Patient verbalises if conscious						
Dyspnoea **Goal: Breathlessness is not distressing for patient** • Patient verbalises if conscious. • Consider need for positional change.						
Other symptoms (e.g. oedema, itch)						
Treatment/procedures ***Mouth care*** **Goal: Mouth is moist and clean** • See mouth care policy • Mouth care assessment **at least** 4 hourly • Frequency of mouth care depends on individual need • Family/other involved in care given						
Micturition difficulties(bladder problems) **Goal: Patient is comfortable** • Urinary catheter if in retention • Urinary catheter or pads, if general weakness creates incontinence						
Medication **(If medication not required please record as N/A)** **Goal: All medication is given safely & accurately** • If McKinley Pump in progress check at least 4 hourly according to monitoring sheet						
Signature						

Name: .... CHI no: .... Date: ....

Codes (please enter in columns) A= Achieved V=Variance (not a signature) **If you chart "V" against any goal, please complete variance sheet** **If patient not symptom free, carry out appropriate intervention and reassess**		***08:00***	***20:00***
Mobility/Pressure area care	**Goal: Patient is comfortable and in a safe environment** • Clinical assessment of: Skin integrity Need for positional change Need for special mattress Personal hygiene, bed bath, eye care needs		
Bowel care	**Goal: Patient is not agitated or distressed due to constipation or diarrhoea**		
Psychological/ Insight support ***Record significant discussions in multidisciplinary notes page***	***Patient*** **Goal: Patient becomes aware of the situation as appropriate** • Patient is informed of procedures • Touch, verbal communication is continued		
	Family/other **Goal: Family/other are prepared for the patient's imminent death with the aim of achieving peace of mind and acceptance** • Check understanding of nominated family/others / younger adults / children • Check understanding of other family/others not present at initial assessment • Ensure recognition that patient is dying & of the measures taken to maintain comfort • Chaplaincy Team support offered		
Religious/ Spiritual support	**Goal: Appropriate religious/spiritual support has been given** • Patient/other may be anxious for self/others • Support of Chaplaincy Team may be helpful • Consider cultural needs		
Care of the family /others	**Goal: The needs of those attending the patient are accommodated** • Consider health needs & social support. Ensure awareness of ward facilities		
Nurse's / Carer Signature.. Early: .... Late:			

Repeat Continuous Evaluation every 24 hours

Spare sheets available as required.

Visits by members of MDT team and specific discussions should be recorded in multidisciplinary notes page at back of LCP

Name: .... CHI no: .... NHS no: ....

Variance analysis

What Variance occurred & why?	Action Taken	Outcome
Signature................................... Date/Time...................................	Signature................................... Date/Time...................................	Signature................................... Date/Time...................................
Signature................................... Date/Time...................................	Signature................................... Date/Time...................................	Signature................................... Date/Time...................................
Signature................................... Date/Time...................................	Signature................................... Date/Time...................................	Signature................................... Date/Time...................................

Name: .... CHI no: .... NHS no: ....

Variance analysis

What Variance occurred & why?	Action Taken	Outcome
Signature................................... Date/Time..................................	Signature................................... Date/Time..................................	Signature................................... Date/Time..................................
Signature................................... Date/Time..................................	Signature................................... Date/Time..................................	Signature................................... Date/Time..................................
Signature................................... Date/Time..................................	Signature................................... Date/Time..................................	Signature................................... Date/Time..................................

Name: .... CHI no: .... Date: ....

Multidisciplinary progress notes

Time/Date	*Comment*	*Signature*

Name: .... CHI no: .... Date: ....

SECTION 3: Care After Death

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

Persons present: ....

Notes: ....

....

Signature: ....

Care after death		
	Goal 12: GP Practice contacted re patient's death Date __/__/__ • If out of hours contact on next working day Message can be left with receptionist	**A** ☐ **V** ☐
	Goal 13: Procedures for laying out followed according to care home policy • Carry out specific religious / spiritual / cultural needs - requests	**A** ☐ **V** ☐
	Goal 14: Procedure following death discussed or carried out **Check for the following:** • Explain mortuary viewing as appropriate • Family aware cardiac devices (ICD's) or pacemaker must be removed prior to cremation • Post mortem discussed as appropriate. Ensure Death Certificate completed Complete Cremation Form – part 1	**A** ☐ **V** ☐
	Goal 15: Family/other given information on care home procedures • Information booklet given to family/other about necessary legal tasks •	**A**☐ **V** ☐
	Goal 16: Care Home policy followed for patient's valuables & belongings • Belongings and valuables are signed for by identified person • Property packed for collection. • Valuables listed and stored safely Arrange for uplift of clinical equipment and cancellation of supplies / services	**A**☐ **V** ☐
	Goal 17: Necessary documentation & advice is given to the appropriate person • Notify care commission of death Death entered in patients register	**A** ☐ **V** ☐
	Goal 18: Bereavement leaflet given • Information leaflet on grieving and local support given	**A** ☐ **V** ☐
	If you have charted "V" against any goal so far, please complete variance sheet at the back of the pathway before signing below **Health Professional** **signature**: .... Date:	

RESPIRATORY TRACT SECRETIONS

PRESENT	ABSENT
Hyoscine butylbromide (Buscopan®) 20mg sc bolus injection. Consider 40 – 80mgs via McKinley syringe pump (Hyoscine hydrobromide 400 micrograms sc may be used but can cause sedation or confusion)	Prescribe hyoscine butylbromide (Buscopan®) 20mg sc hourly prn

NAUSEA AND VOMITING

PRESENT	ABSENT
Consider one of the following: Haloperidol 2.5 - 5mg/ 24hr via McKinley syringe pump (and 1mg sc prn) Or Levomepromazine 5 -20mg / 24hr sc via McKinley syringe pump (and 2.5mg sc prn Increase syringe pump dose if 2 or more prn doses needed If nausea / vomiting not controlled, call the advice line (01236766951)	Prescribe haloperidol 1mg sc 12 hourly prn Or Levomepromazine 2.5mg sc 8 – 12 hourly prn

TERMINAL RESTLESSNESS AND AGITATION

PRESENT

If evidence of confusion or hallucinations (e.g. Plucking at bed sheets reaching for invisible objects) give haloperidol 2.5mg sc stat and prn

Consider Haloperidol 2.5 – 5mg/24hr via McKinley syringe pump

If evidence of anxiety or just simple restlessness, give midazolam 2.5mg sc stat and prn

NB. The above drugs can be used together and combined in a McKinley syringe pump.

Doses via McKinley syringe pump should be titrated according to need, if stat doses are helpful.

If agitation is not controlled, call the advice line (01236766951)

ABSENT

Prescribe Haloperidol 2.5mg sc prn for confusion or hallucinations

and

Midazolam 2.5mg sc prn for anxiety or restlessness

Practice Points

- Opioid analgesics should not be used to sedate dying patients
- Benzodiazepines alone do not improve cognition in confusion states and may worsen it

PAIN

If patient is taking strong opioids orally, convert to the subcutaneous route.

To convert from **oral morphine** to:
A. 24hr sc infusion of morphine
Divide the **total** daily dose of morphine by 2
(e.g. MST 30mgs bd = morphine 30mg / 24hr via syringe pump)
B. 24hr sc infusion of diamorphine
Divide the **total** daily dose of morphine by 3
(e.g. MST 30mg bd = diamorphine 20mg / 24hr via syringe pump)

To convert from **oral oxycodone** to 24hr sc infusion of oxycodone
Divide the total daily dose of oxycodone by 2
(e.g. Oxycontin 30mg bd = oxynorm 30mg / 24hr via syringe pump)

PATIENT IS IN PAIN

If on regular strong opioid, offer appropriate sc dose of breakthrough medication (see below)

If not on regular strong opioid, use morphine 2.5mg sc prn. If 2 or more doses needed in 24 hours then consider a McKinley syringe pump (e.g. Morphine 10mgs / 24hr sc)

Review pain control daily.
Consider increase in regular dose if 2 or more breakthrough doses needed.

PATIENT'S PAIN IS CONTROLLED

Ensure sc analgesia is prescribed prn.

If on regular strong opioid, see below for breakthrough doses.

If not on regular strong opioid, prescribe morphine 2.5mg sc prn

Choice of Opioid for use in a Syringe Pump:
1st Line: Morphine or Diamorphine
2nd Line: Oxycodone
3rd Line: Alfentanil (seek specialist advice)

Breakthrough dose should be 1/6 of total daily dose of strong opioid. (e.g. Morphine 90mg sc via syringe pump = morphine 15mg sc prn for breakthrough

For breakthrough dose when using Fentanyl patches, please consult Palliative Care Guidelines or call advice line (01236766951)