NHS Lanarkshire

Preferred Place of Care

Palliative Care Audit

Report

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Introduction

‘Preferred Place of Care’ is a phrase which has recently been used and understood to mean the stated preferred place of death of someone who is chronically ill. Many people may in fact not have strong feelings about the place of their death, but may express a desire to be at home for as long as possible. Others may think they would wish to die at home (or elsewhere) but later change their minds as symptoms or circumstances change. The Preferred Place of Care (PPC) project aims to help those with chronic illness remain in the place of their choice with appropriate levels of care and support for as much time as possible.

A ‘YOUGOV’ survey conducted by Marie Curie Cancer Care (MCCC) in 2005 found that, when given the choice, 75% of people would prefer to be cared for at home in the end-of-life period, and only 4% would opt to die in an acute hospital setting.

In Lanarkshire, we have comparative statistics for ***all*** patients, with information from ISD Scotland (2007) showing only 23% dying at home and 59% in acute hospitals. For cancer deaths alone in the same year 28% died at home with 53% dying in hospital.

In its Palliative Care Strategy, NHS Lanarkshire (NHSL) highlighted its intention to provide more community-focused care to all patients and set an aspirational target of 40% home deaths (for all patients). It is recognised that acute hospital admission may seem like the only or best option during a crisis of health or social care needs. However this can lead to a longer period of inpatient care than was intended by the referrer (and/or patient) either because of medical complications, a reassessment of the safety of living at home, or a breakdown of previous levels of support from informal carers.

Therefore to work towards the NHSL target of increased numbers of home deaths, some work was necessary to identify why unplanned admissions for palliative patients occur in the first instance.

The Preferred Place of Care (PPC) project includes an audit of acute hospital admissions during the palliative phase of chronic illness to determine the wishes of the patient and referrer in an attempt to identify any changes to care or to education which could help avoid unwanted admissions in the future.

This audit was supported by the Lanarkshire Palliative Care MCN and facilitated by a team of clinicians and staff from clinical effectiveness working as the PPC project committee.

Objectives

- To establish numbers of patients in the palliative phase of an illness experiencing unplanned hospital admission to each of the 3 district general hospitals in Lanarkshire over a 7 day period (different weeks for each hospital)
- identify the reason for admission
- explore the experience of patients (and carers) and determine their true wishes in relation to hospital admission
- interview professional referrers and elucidate their opinions regarding the need for acute care
- identify gaps in current service provision
- develop an action plan to bridge the identified gaps in care

Our approach

- Current literature and policies in relation to PPC was examined
- Audit proforma developed by Clinical Effectiveness Department
- Teams of palliative care specialist nurse and physician were established to undertake audit in each hospital
- LTC (Long Term Condition) staff agreed to perform follow-up interviews (by telephone) with professional referrers
- Palliative care staff attended medical and surgical receiving wards of Wishaw (November 2009), Hairmyres (December 2009) and Monklands (March 2010) hospitals daily for 7 days (Monday to Sunday)
- All acute medical and surgical admission case notes were examined
- All patients with previously established diagnoses of a palliative condition were identified (classification borrowed from the community Gold Standards of Palliative Care documentation)
- All palliative cases were audited the day following admission and patients were interviewed if competent and willing
- Patients were asked if they had really wanted to be admitted the previous day and if they were aware of anything which would have prevented the need for admission
- CHI numbers and information gathered were passed to LTC team, who attempted to identify and contact professional referrers of patients to hospital. (Focus was on cases where the patient had not desired admission or where the need for hospital care was not immediately apparent.)
- Professional referrers were asked if, ideally, they would have wished for acute hospital admission for the patient and, again, if they could identify any factors which could have prevented it
- All audit information passed to clinical effectiveness department for analysis and reporting

What we found

The following report presents the data collection and analysis during the audit of preferred place of care, carried out within all three acute settings of NHS Lanarkshire between November 2009 and March 2010.

There were 730 emergency admissions during the audit period and of these, 128 were identified as being eligible to be recorded on a community palliative care register (GSF, QoF 2006). Twenty-five of the 128 palliative patients (20%) are known to have died during the recorded admission. Of the 128 only 74 were able to answer the audit questions, the rest were excluded because of cognitive impairment or extreme physical frailty. When invited, a further 3 patients declined to be interviewed.

Demographics

Of the 128 patients included in the audit, 61% were female and 39% male. Analysis shows the mean age as 77 years, with 81% over 60 years old, 13% 41 – 60 years, and 5% within the 25 – 40 years age group.

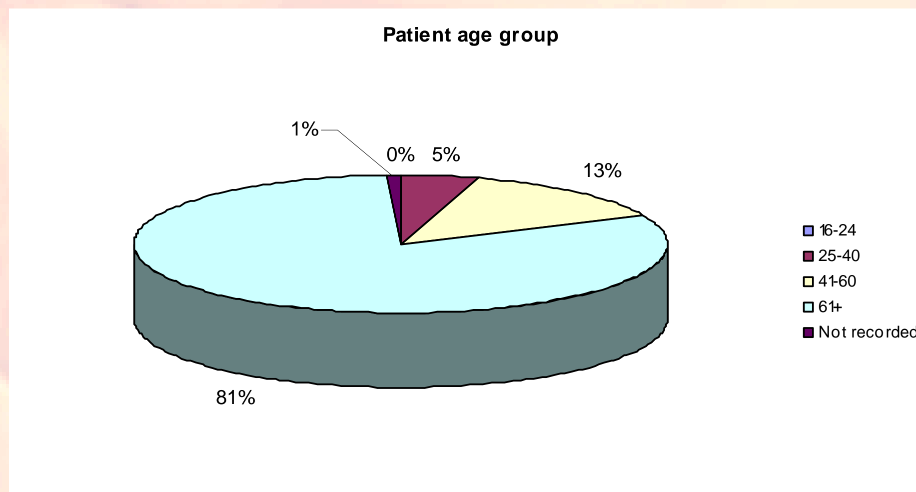


Figure 1 Patient Age Group

Hospital of Admission

Of the 128 patients included in this audit, 40% were admitted to Wishaw General, 33% to Monklands District General and 27% to Hairmyres Hospital.

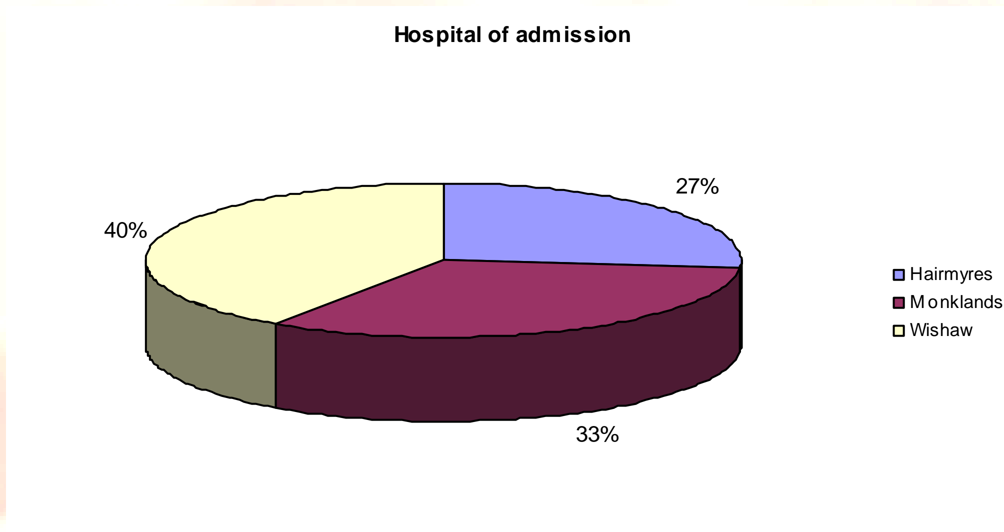


Figure 2 Admissions per hospital

Time of Admission

The majority of patients with palliative care needs were admitted during the out of hours period as illustrated in table 1.

Was patient admitted out of hours (n)	
Yes	83
No	41
Not recorded	4

Table 1 time of admission

Diagnosis

Of those acute admissions with a previously established palliative condition:

- 39 (30%) patients were admitted with an advanced metastatic malignancy
- 29 (23%) patients were diagnosed with chronic respiratory disease
- 25 (20%) had dementia
- 19 (15%) patients had general frailty with no more specific diagnosis
- 5 (4%) were admitted with chronic heart failure (CHF)
- 6 (5%) patients had a previous CVA
- 7 (5%) had Multiple Sclerosis (MS)
- 5 (4%) not recorded
- 2 (2%) had a diagnosis of Parkinson’s Disease
- 1 (1%) patient had Motor Neurone Disease (MND)

Please note that patients having more than one palliative condition may have been recorded twice.

The diagnosis was not recorded in 5 (4%) patients. 39 (30%) patients were admitted with advanced malignancy, compared with 85 (66%) who were admitted with a non-malignant condition or conditions.

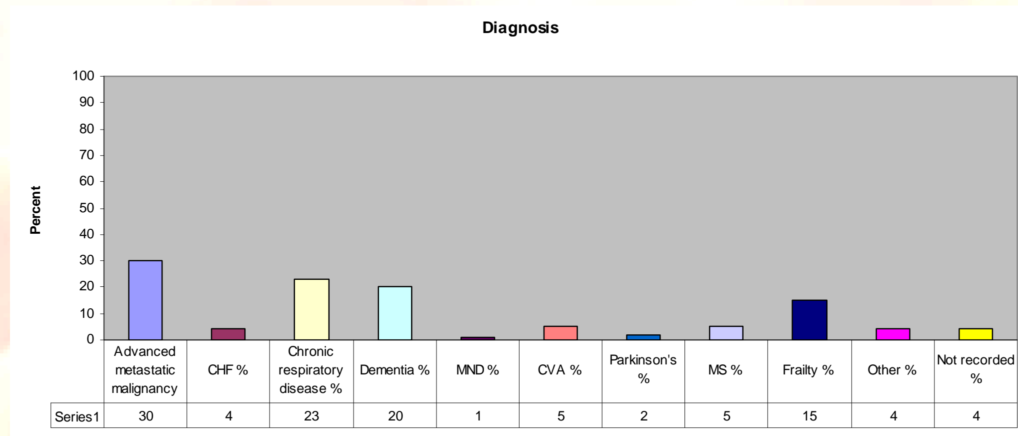


Figure 3 Diagnoses

Reason for Admission

One of the objectives of this piece of work was to establish the reasons for hospital admission for this group in the hope of identifying a service or educational gap. Figure 4 illustrates the reasons for admission for all 128 patients. Please note individual patients may have had a number of reasons for admission.

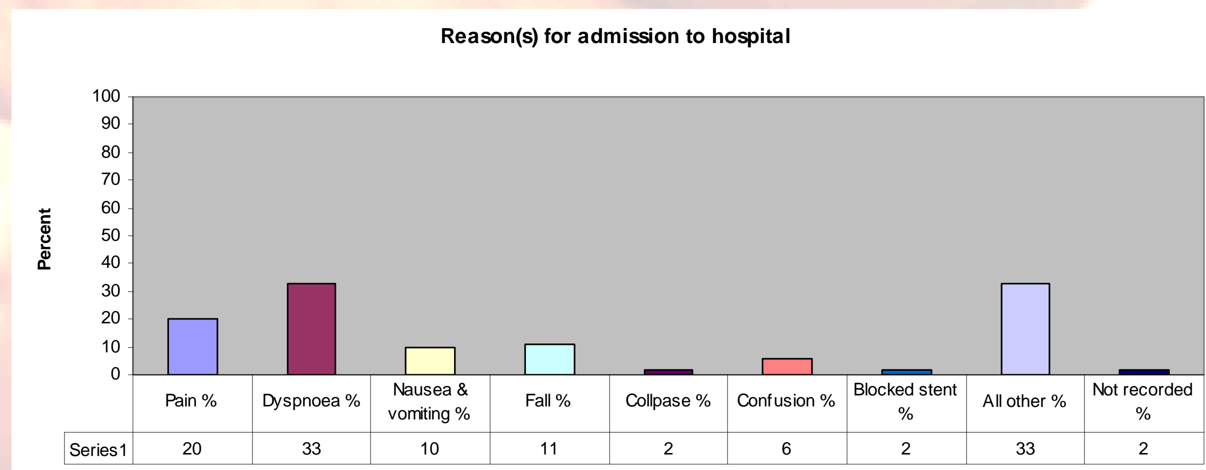


Figure 4 Reason for hospital admission

Other reasons for admission to hospital included:

- Sepsis
- UTI
- Acute renal failure
- Decreased mobility

- Rectal bleeding
- Chest infection
- Headache
- Head injury
- Dehydration
- Wound problem
- Delusions
- Seizure
- GI Bleed
- Social
- Fever

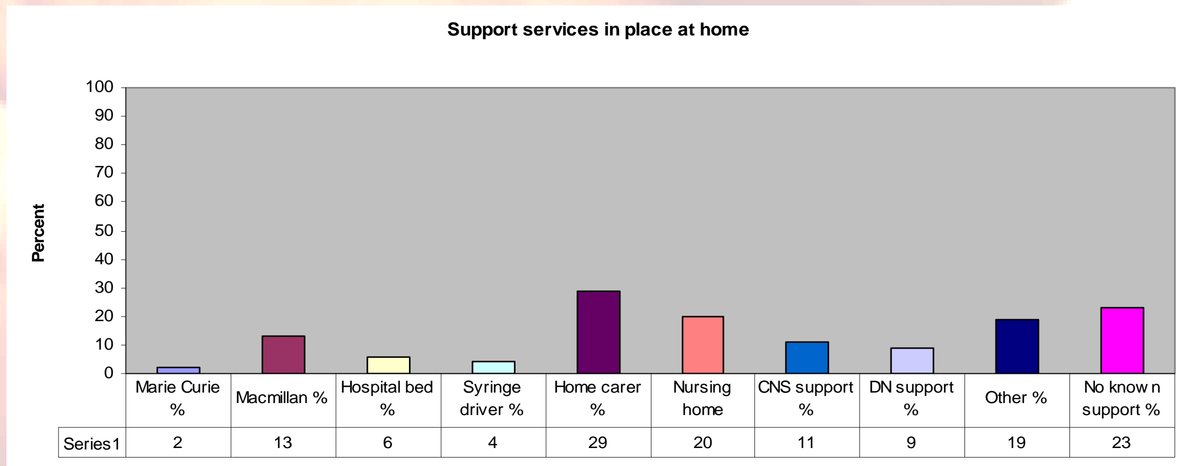
Who made the referral to hospital?

Of the 128 patients included within this audit, 96 (75%) were referred for admission by a healthcare professional. This included patients' GPs, out of hours GPs, Clinical nurse specialists, paramedic(s), nursing home staff, community hospital staff, oncology staff, and NHS 24. Nine (7%) patients self-referred. Nineteen (15%) of the 128 were referred by their family/carers. For 4 (3%) patients the referrer was not recorded.

Support services in place at home

Palliative care patients being admitted to hospital may have complex health and social care needs. Where appropriate, questions were asked to establish what services were currently in place.

Figure 5 indicates a range of health and social care support already in place.



	Marie Curie %	Macmillan %	Hospital bed %	Syringe driver %	Home carer %	Nursing home	CNS support %	DN support %	Other %	No know n support %
Series1	2	13	6	4	29	20	11	9	19	23

Figure 5 Services in place

Other support services included:

- Stair lift
- Family
- Home Oxygen

- Stoma nurse
- Alert system
- Day Hospice attendee
- Private cleaner
- Home help

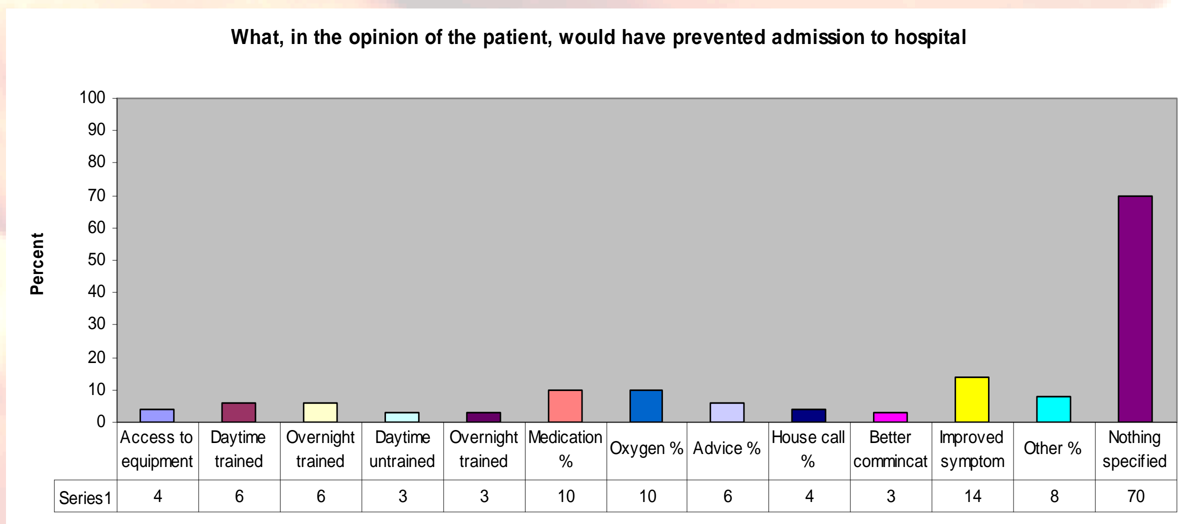
Did you really want to be admitted?

This was the main question put to the palliative patients. Most stated that they had agreed to admission when told it was necessary by a professional; very few had openly objected to the idea. However when asked if it was what they would have preferred ideally, 20 admitted they did not want admission (28% of those interviewed).

When asked if they wished to be admitted to hospital 49 of the 71 patients answered yes. The remainder did not indicate a preference.

Preventing admission – patient perspective

The project team was keen to establish the opinion of patients regarding their medical and nursing care needs. Patients were asked if they were aware of anything that could have prevented the need for admission. Ten patients (14%) felt that improved symptom control may have prevented their admission. Seven patients (10%) stated that home oxygen may have prevented this particular admission with a further 7 (10%) stating that access to medication may have helped.



	Access to equipment	Daytime trained	Overnight trained	Daytime untrained	Overnight trained	Medication %	Oxygen %	Advice %	House call %	Better commincat	Improved symptom	Other %	Nothing specified
Series1	4	6	6	3	3	10	10	6	4	3	14	8	70

Figure 6 Patient opinion

Of the 71 patients who agreed to answer questions regarding their admission, 50 (70%) could not offer any suggestions as to what may have helped avoid this particular admission.

Telephone interview with Referrer

Information regarding the acute hospital admission, including the CHI number, was passed to the Long Term Conditions Team for follow- up. Attempts were made to

identify and contact professional referrers of patients to hospital. The focus of these telephone interviews was on cases where the patients had not desired admission or where the need for hospital admission was not immediately apparent. Thirty (of the 96 professional referrers) were successfully contacted.

Professional referrers were asked if, ideally, they would have wished for acute hospital admission for the patient and if not, to identify any factors which could have prevented it.

Of the referrers contacted 70% (n= 21) stated that acute hospital admission was necessary for their patients. Only 10% (n=3) would have preferred to keep the patient at home. The preference of 6 referrers (20%) was not recorded.

Professional referrers were asked what, in their opinion, would have prevented hospital admission. Of the 34 referrers contacted, 2 stated that access to medication would have prevented their patient being admitted. One referrer felt that some advice would have helped; 5 (15%) stated that improved symptom control may have helped with 3 (9%) suggesting that a record of their patients' wishes may have prevented their admission. Two referrers provided other reasons.

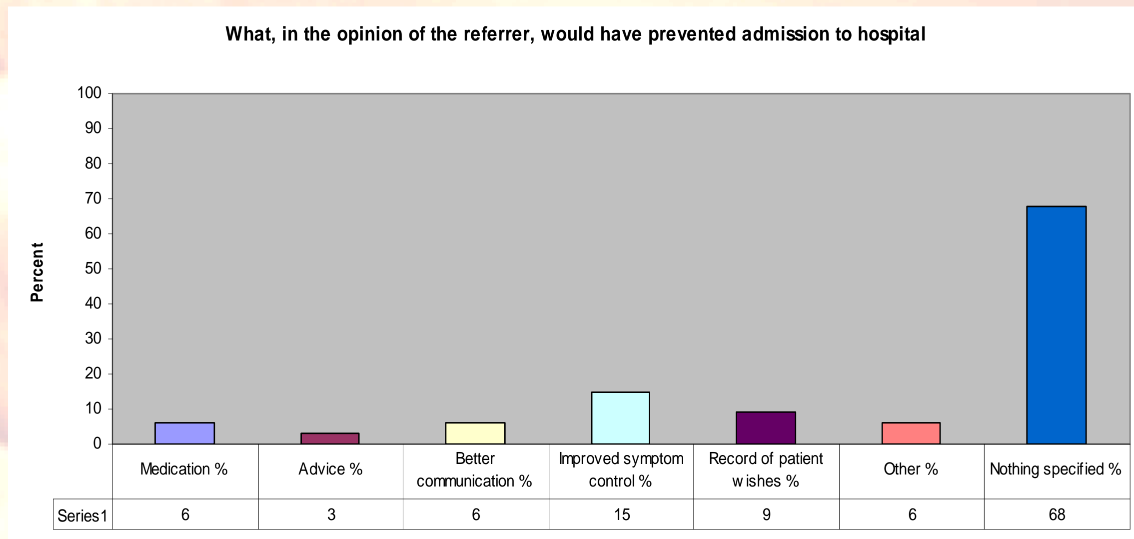


Figure 7 Referrer opinion

Of the professional referrers contacted, 23 did not specify what they thought may have prevented the admission to hospital for that patient.

Discussion

National strategy emphasizes the importance of patient choice, including preferences regarding end of life care. This leads to an expectation for health and social care professionals to determine patients' preferences. Within Lanarkshire, we have an aspirational target of 40% home deaths, an improvement from the current 23%. This audit has allowed us to explore the preferences of a small cohort of palliative care patients regarding acute hospital admission in what was predicted to be the last year of life.

During the period of data collection a total of 730 patients were admitted to medical and surgical receiving units. As expected, a significant 18% of all emergency admissions had a chronic progressive illness, which was advanced enough to meet the criteria for being included in a community palliative care register (GSF, QoF 2006). This may equate to being predicted to have a life expectancy of 6 – 12 months (GSF, QoF 2006).

Most patients were referred to hospital by a healthcare professional with the majority (81%) over 60 years of age. Patients had a wide range of chronic conditions and general frailty, but only 30% of the identified ‘palliative patients’ had a malignancy. The biggest group of those with non-malignant conditions had respiratory disease and dementia. Dementia and general frailty was the diagnosis for most of the rest leading to a large percentage being unable to answer questions or offer an opinion regarding their admission. For some, hospital admission seemed unavoidable. We must take cognizance, however, of the 20 patients who clearly stated they would have preferred to have stayed at home. This number may have been larger if patients with cognitive impairment had been able to state preferences in advance, or if those interviewed had more time to contemplate alternatives to hospital care. Another consideration could be that patients felt ‘put on the spot’ and simply answered that they had agreed with the professional referrer’s advice - that hospital admission was best.

The clinical reasons for admission were many and varied but the majority of patients were identified as having an uncontrolled symptom as the main reason for admission. It seems that health care professionals could benefit from further education and support concerning symptom management. Increased awareness that 24 hour telephone palliative care advice, including symptom control, is available via St Andrews Hospice may be beneficial.

The recent launch of NHS Lanarkshire’s Anticipatory Care Plans (ACPs) will help to capture preferred wishes for care. It may also help in the early identification of increased symptoms or a decline in the patient’s condition. Appropriate action and personalised symptom management plans should be available to ensure the patient stays within their preferred place of care, thus avoiding unnecessary or unwanted trips to hospital. This may include the necessity for immediate access to specific medication.

This approach is supported by the use of the Lanarkshire Palliative Care Assessment Tool (LPCAT) and the Liverpool Care Pathway (LCP) (Appendix I).

If we are to reach our aspirational target of 40% deaths at home, then further work is required to ensure that people have the necessary support at home. Patients must be given the opportunity to communicate their preferences for the place of their death, and also their medical and nursing care during the final stages of their illnesses. We must ensure that the outcome of such sensitive discussions is communicated to the wider health and social care team, to prevent decisions or referrals being made in contradiction to patient wishes, as far as is possible. If gaps in provision of equipment, medication or personal care make compliance with patient preference impossible, there should be a means of recording and addressing this to ensure ongoing improvement in service provision.

Recommendations

Reflecting upon the findings of the preferred place of care (PPC) audit, the project group would like to make the following recommendations:

1. Consider a campaign to raise awareness that St Andrew's Hospice offers 24 hour telephone palliative care advice, including symptom control.
2. Support the use of Anticipatory Care Plans.
3. Support District Nurse Care Managers in the provision of palliative care.
4. Support care homes to meet the end of life wishes for their residents.
5. Continue to provide palliative care education which supports best practice in palliative care for all.

The PPC audit team would like to express their thanks to all who took part.

References:

Information Statistics Division (2007) NHS Scotland

Marie Curie Cancer Care (2005) Supporting the Choice to Die at Home Campaign in Scotland

Quality & Outcomes Framework (2006) General Medical Services Contract, British Medical Association, London

Thomas K, Gold Standards Framework (2009), National Gold Standards Framework Centre, Walsall

The PPC Audit Project Team

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Appendix I

Liverpool Care Pathway

(Community Version)

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

GP .... District Nurse ....

District Nurses	Mon – Fri 08.45am – 5pm Sat / Sun / Public Holidays	Telephone .... On –call mobile ....
Out of Hours Nurses Base	Mon – Sun 6pm – 10pm Mon – Sun 10pm – 8am	Telephone..................................... Telephone.......................................
NHS 24		Telephone 08454 242424
St Andrew's Hospice	24hour telephone advice line	Telephone 01236 - 766951
Macmillan Nurse	Mon – Fri 9am – 5pm	Telephone ....

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 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**: .... Female ☐ Male ☐ DOB:............................... .... 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.medications **A** ☐ **V** ☐ **N/A** ☐ Artificial hydration / nutrition **A** ☐ **V** ☐ **N/A** ☐ Not for cardiopulmonary resuscitation recorded **A** ☐ **V** ☐ **N/A** ☐ (Please record below & complete appropriate associated documentation - policy/procedure) **Deactivate cardiac defibrillators (ICD's)** **A** ☐ **V** ☐ **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 **A** ☐ **V** ☐ 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 **A** ☐ **V** ☐ **N/A** ☐

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** (document any specific requirements) 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** ☐ **No** ☐ 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** ☐ 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: Not applicable to the community setting**
	Goal 8: Not applicable to the community setting
Communication with primary health care team	**Goal 9: G.P. Practice is aware of patient's condition** **A** ☐ **V** ☐ **9a Out of Hours Service aware** **A** ☐ **V** ☐ **9b EPCAS completed** **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. Family/other involvement in physical care. Not to call emergency ambulance discussed. Not to attempt to resuscitate discussed. Contact numbers for 24 hour cover available.
	Nurse's Signature...............................**Date**...**Time**..................................

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

Section 2 Patient problem/focus *Record time of visit*	Date Time	Date Time	Date Time	Date Time	Date Time	Date Time
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 each visit** • 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 incontinent						
Medication **(If medication not required please record as N/A)** **Goal: All medication is given safely & accurately** • If McKinley pump in progress check at each visit according to monitoring sheet						
Signature						

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							
Section 2 *Continued*	*Patient problem/focus* *Record time of visit*	Date Time	Date Time	Date Time	Date Time	Date Time	Date Time
Mobility/Pressure area care **Goal: Patient is comfortable and in 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 **Patient** **Goal: Patient becomes aware of the situation as appropriate** • Patient is informed of procedures • Touch, verbal communication is continued							
Psychological/Insight support **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.							
Health Professional signature each visit							

Multidisciplinary progress notes

Time/Date	*Comment*	*Signature*

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:..........................

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:.........................

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 community 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 by contacting Funeral Director • Family aware cardiac devices (ICD's) or pacemaker must be removed prior to cremation • Post mortem discussed as appropriate. • Input patients death on community computer system	**A** ☐	**V** ☐
	Goal 15: Family/other given information on community procedures • information booklet given to family/other about necessary legal tasks • Relatives/other informed to ring Registrars Office to make an appointment	**A** ☐	**V** ☐
	Goal 16: Community setting only **Arrangements in place for the cancellation / uplift of any clinical equipment / supplies / services**	**A** ☐	**V** ☐
	Goal 17: Necessary documentation & advice is given to the appropriate person • 'What to do after death' booklet given (DHSS)	**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, please complete variance sheet before signing below **Health Professional** **signature**: .... Date:		

RESPIRATORY TRACT SECRETIONS

PRESENT

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)

ABSENT

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

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 pain)

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