Care Plan for End of Life

(A hospital label may be placed here where applicable)

Print Name_____ NHS No_____

Hospital Number *(where applicable)*_____ Date of Birth_____

Address_____

Date of Birth_____ Ward/Place of Care_____

GP/Consultant_____ Contact _____

District Nurse/ Clinical Nurse Specialist _____

Role_____ Contact Details_____

Date started: _____ Time *(24hr clock):* _____

Doctor's name_____Signature_____

Role_____ GMC No _____

Nurse's name _____Signature_____

Role_____

Where to get further advice and support:

East Cheshire Clinical Commissioning Group	South & Vale Royal Clinical Commissioning Groups
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**	**Macmillan Specialist Palliative Care Team (*Mon-Fri 9-5)* Tel 01606 544155** **St Luke's Hospice Helpline (24 hour advice available) Tel 01606 555489**

Also refer to:

The 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 Care of the Dying Person; Duties & Responsibilities of Health & Care Staff (2014)

All personnel completing the care plan please sign below:

Name (print)	Full signature	Initials	Professional title	Date

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, Dementia Care

Please refer to www.cheshire-epaige.nhs.uk and click on 'care plan for end of life' on the homepage

Further advice concerning use of this care plan can be obtained by contacting the Service Development Team- End of Life Partnership Tel 01625 666996/ 01606 555698

ALL STAFF

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 agree 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:

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

Lead Clinician *(must be completed a Senior Doctor: ST3 or above)*

Name_____ Signature_____Role_____

Details of other clinicians involved in the initial assessment where a decision has been made to commence the Care Plan:

Name_____ Signature_____Role_____

Name_____ Signature_____Role_____

Name_____ Signature_____Role_____

Name_____ Signature_____Role_____

INVOLVEMENT OF THE INDIVIDUAL & THEIR FAMILY AND/OR SIGNIFICANT OTHERS DURING INITIATION OF THIS CARE PLAN:

Is the individual aware of this plan of care? Yes/ No *(if no explain reason. If the individual lacks capacity then this should be expanded upon in **Section 1**)*_____

_____

Are the family and/or significant others aware of the plan of care? Yes/No
(Details of conversations including names of people involved can be documented on page 12). Where the family/significant others have not been informed or involved, a clear rationale MUST be given on page12.

MEDICAL & NURSING TEAM DAILY REVIEW

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)
- The observations and judgements of family members/significant others should be taken into account. A second opinion may be sought where disagreements occur or where additional reassurance is thought to be helpful
- Supporting documentation concerning the daily review should be written in the continuation notes on pages 16-20 (spare continuation sheets are also available)

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

*** Refer to page 8 for specific details of staff groups that have been delegated responsibility**
Clinicians must sign below following each daily review

Senior Clinician (*or person with delegated responsibility***):** Print name________________________________ Signature______________________ Role_________ Date/Time(24hr clock)___________ Place______________
Senior Clinician (*or person with delegated responsibility***):** Print name________________________________ Signature______________________ Role_________ Date/Time(24hr clock)___________ Place______________
Senior Clinician (*or person with delegated responsibility***):** Print name________________________________ Signature______________________ Role_________ Date/Time(24hr clock)___________ Place______________
Senior Clinician (*or person with delegated responsibility***):** Print name________________________________ Signature______________________ Role_________ Date/Time(24hr clock)___________ Place______________
Senior Clinician (*or person with delegated responsibility***):** Print name________________________________ Signature______________________ Role_________ Date/Time(24hr clock)___________ Place______________
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 p16-20- spare sheets also available)*

Section 1- Assessment & 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, and/or their family/significant others
- Proposed plan of care including discussion about;
    - Ceiling of care/CPR status
    - Risks and benefits of nutrition and hydration
    - Discontinuation of routine observations and tests
    - Symptom control and medications prescribed for pain, nausea and vomiting, dyspnoea, agitation and chest secretions – including the need to commence a syringe pump if required
- Any communication difficulties to consider e.g. deafness, speech difficulties. Is there a patient passport or is an interpreter required?
- For those who lack capacity and have no-one else to support them (other than paid staff), an **Independent Mental Capacity Advocate* (IMCA) MUST be consulted**

*****_The availability of an IMCA should not delay or preclude the delivery of good quality end of life care_

Date/Time of completion: *(24hr clock)*	
Place of Care:	

Notes	**Signature/Role**

INITIAL ASSESSMENT: DOCTORS & NURSES

Patient Name……………………………Date of Birth…………………………….NHS no…………………………

Notes	Signature/Role

INITIAL ASSESSMENT: DOCTORS & NURSES

Section 2- Management Plan

To be completed by a Doctor

This **person is expected to die from natural causes and as a result of their advancing** *(insert relevant illness/condition)*……

Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) has been discussed and recorded in the medical record. Please record communication below: (***NB: a DNACPR form is still required***)

Has the individual concerned been informed of the DNACPR decision? Yes/ No/ Unconscious

……

……

……Date/Time of discussion *(24hr clock)*……

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*

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

Doctor's Name (Print)……Signature……Role……

Date & Time *(24hr clock)* **of management plan completion:**		**Place of care**	
Does this person have an Implantable Cardioverter Defibrillator (ICD) in situ? *If yes, refer to local policy re deactivation, and contact the individual's cardiology team in hours*		**Yes**	**No**
Where applicable give details of actions taken to facilitate deactivation of ICD: Signature_____ Role_____			

Insert details of medical and nursing interventions to be <u>discontinued</u>: *eg. blood tests, observations*

Notes:	**Signature/role**

Insert details of medical and nursing interventions to be <u>continued:</u> *e.g oxygen*

Notes:	**Signature/role**

INITIAL ASSESSMENT DOCTORS <u>ONLY</u>

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

Are there any specific instructions concerning the maintenance of appropriate hydration and nutrition for the person? *e.g. continuation or discontinuation of artificial fluids.* **If there are, please detail below:**

Notes:	**Signature/Role**

DELEGATED RESPONSIBILITY

Please detail below the staff members or staff groups to whom you are happy to delegate responsibility for the daily review i.e. District/Community Nurses, (for further information see pg 4).

PLEASE NOTE THAT IF THIS SECTION IN NOT COMPLETED STAFF WILL BE ADVISED TO REQUEST A SENIOR DOCTOR TO CARRY OUT THE DAILY REVIEW i.e. ST3 AND ABOVE

Notes	**Signature/Role**

INITIAL ASSESSMENT DOCTORS ONLY

Section 3- Preferences and 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 consider consulting with the IMCA service*.**

*****_The availability of an IMCA should not preclude the delivery of good quality end of life care_

What is most important to this person at this time? *(Continue overleaf if required)*

Date/Time/Place	Notes:	Signature/Role

Details of any Advance Statement of Wishes/expressed preferences e.g. *Preferred Priorities for Care* and/or of any ADRT or Lasting Power of Attorney for Health & Welfare:

Date/Time/Place	Notes:	Signature/Role

Please sign below to confirm that relevant documentation has been seen, and is valid to support either an ADRT or LPA for Health & Welfare:

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

NB: Please ensure that the ADRT or LPA is flagged/alerted to according to organisational procedures e.g. hospital notes, EMIS web template

INITIAL ASSESSMENT: MULTIPROFESSIONAL TEAM

Please indicate the 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 below what has been done to facilitate achievement of this preference, and any reasons why achievement of PPoD is not possible:

Date/Time/Place	Notes:	Signature/Role

Has the individual and/or their family/significant others indicated any cultural/religious traditions that should be followed now or after death?

Notes			
Religious tradition (if applicable):			
Detail any expressed preferences concerning the support of the Chaplain or other religious or spiritual advisor:			
Where applicable, contact details of religious or spiritual advisor:			
Where applicable, identified cultural, spiritual, or religious needs immediate or after death:			
Signature/role		Date/Time *(24hr clock)*	

Section 3- Continuation notes

Date/Time/Place	Notes:	Signature/Role

Section 4- 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. District Nurse, 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

Has the **"What to expect during the last days and hours"** leaflet been given to the family/significant others? *(Please circle)* **Yes** **No** **Offered but declined**

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

Are there any specific communication needs to consider for family members/significant others?
E.g. concerns, fears, interpreter required, deafness. *If yes please detail below*

Date/Time/Place	Notes:	Signature/Role

Next of Kin/ Nearest Relative Details	
Print Name	
Relationship	
Contact details *(address & Tel)*	
Conditions of contact	Contact anytime ☐ Do not contact during the night ☐ ONLY Contact 1st contact as detailed below ☐ Other directions (*please specify*):

1st Contact (if different from next of kin)	2nd contact
Print Name: Relationship: Address: Telephone: Contact: Anytime☐ Not during the Night☐	Print Name: Relationship: Address: Telephone: Contact: Anytime☐ Not during the Night☐

Date/Time of completion: *(24hr clock)*	
Place of Care:	

With whom have conversations taken place?

List all the names of family members and/or significant others involved in conversations	Signature/role

Please use this space to record details of specific conversations held with family members and/or significant others including dates & times (if different from the above).

Date/Time/Place *(if different from above)*	Notes:	Signature/Role

Section 5- Symptom Control

REVIEW CURRENT MEDICATION:

- Discuss and negotiate the management of symptoms including potential side effects
- Discontinuation of non-essential medications
- Anticipatory prescribing should be targeted at specific symptoms with a clear rationale provided for the starting dose
- Consider the most appropriate route for medication to be given
- Optimise the control of symptoms, seeking Specialist Palliative Care advice where initial measures have failed to provide adequate relief within at most 24 hours
- Review prescribed medications regularly and adjust as needed for effect

CONSIDER THE HOLISTIC MANAGEMENT OF SYMPTOMS i.e. psychological, spiritual, social as well as physical

- Consult with and involve the wider multi-disciplinary team in the management of symptoms
- Seek Specialist Palliative Care Advice where appropriate
- Refer to local guidelines available via **Cheshire EPAIGE** or on the intranet

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

	Please tick when done
PAIN	
AGITATION	
RESPIRATORY TRACT SECRETIONS	
NAUSEA & VOMITING	
BREATHLESSNESS	
Also consider and prescribe for OTHER TREATABLE SYMPTOMS experienced or predicted	

A Syringe Driver may not always be required.
However, staff should ensure that a syringe driver is readily available should this be needed.
Conversations with both the individual and their family/significant others should also include information about when a syringe driver may or may not be indicated

Details of conversations held with the individual and their family and/or significant others concerning the management of symptoms at the end of life:

Date/Time of completion: *(24hr clock)*	
Place of Care:	

Date/Time/Place *(if different from above)*	**Notes**	**Signature/Role**

Section 5 Continuation notes

Date/Time/Place *(if different from above)*	**Notes**	**Signature/Role**

Patient Name……Date of Birth……NHS no……

Section 6- Ongoing Assessment

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:

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

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

Trigger and report to the senior clinician in charge of the individual's care, the need for a daily review therefore prompting the completion of page 4

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

6. Other individualised

(please enter details e.g. tracheostomy care)

The above list is not exhaustive, therefore those providing care should consider the individual needs of the person and/or their family/significant others through ongoing holistic assessment.

ONGOING ASSESSMENT: MULTIPROFESSIONAL TEAM

Date/Time/Place	Ongoing Assessment Supportive Notes (see p15 for numbered principles)	Signature/Role

Date/Time/Place	Ongoing Assessment Supportive Notes: (see p15 for numbered principles)	Signature/Role

Date/Time/Place	Ongoing Assessment Supportive Notes: (see p15 for numbered principles)	Signature/Role

Date/Time/Place	Ongoing Assessment Supportive Notes: (see p15 for numbered principles)	Signature/Role

Date/Time/Place	Ongoing Assessment Supportive Notes: (see p15 for numbered principles)	Signature/Role

Section 7: After Death Care

Verification of death

Date of death .....Time of death *(24hr clock)* .....Place……

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 ..... 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 7) and a trained nurse is verifying death, this section needs to be completed by the nurse (as per the NVoED policy).	
Vital signs checked:	
• No response to painful stimuli (sternal rub)	**Yes** ☐ **No** ☐
• Carotid pulse absent for one minute	**Yes** ☐ **No** ☐
• Heart sounds absent for one minute	**Yes** ☐ **No** ☐
• Respirations absent for one minute	**Yes** ☐ **No** ☐
• Pupils fixed	**Yes** ☐ **No** ☐

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

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

DOCTORS & NURSES

Communication & support after death		***Name (print) Signature/role***
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 • Universal precautions & local policy/procedures including infection risk adhered to • 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/Time**(24hr clock) .....

DOCTORS & NURSES

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
- 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 details

†- 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 † - maximums given as a guide. 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, 3 hrly (max 75mgs/24h†)

ABSENT

Prescribe Cyclizine 50mgs SC, 4-6 hrly (max200mgs/24h†) 'as required'
Or
Haloperidol 1.5-5mgs SC, 4-6 hrly (max 15mgs/24h†) '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

PAIN

PATIENT IS IN PAIN

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 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.
NB:If on fentanyl patches, see separate guidance sheet.

NO

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' doses given indicate).

PATIENT'S PAIN IS CONTROLLED

Is patient already on weak/ strong oral opioid?

YES

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.

NB:If on fentanyl patches, see separate guidance sheet.

NO

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† 10mg/24h.

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