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Last Days of Life Documentation

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Useful Contact Numbers

	York		Scarborough	
	Hospital	Community	Hospital	Community
EOLC Care Educator	01904 721106 01904 725835	07809519754	01723 342446	
Palliative Care Team	01904 725835	01904 724476	01723 342446	01723 356043
Medicines information	01904 725960	0191 2824631	01723 385170	0191 282463
Chaplaincy	Bleep 720		Bleep #6386	
Organ donation	07659171979			
General office/ bereavement office	01904 725445		01723 342177	

For "out of hours" symptom control advice contact

Scarborough	"Palcall", St Catherine's Hospice, Scarborough: 01723 354506
York	St Leonard's Hospice, York: 01904 708553

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If more information is required please seek help from specialist palliative care

Opioid dose conversion chart, syringe driver doses, rescue / prn doses and opioid patches

Use the conversion chart to work out the equivalent doses of different opioid drugs by different routes.
The formula to work out the dose is under each drug name. Examples are given as a guide

Oral opioid mg /24 hour (Divide 24 hour dose by six for 4 hourly prn oral dose)		Subcutaneous infusion of opioid Syringe driver (SD) dose in mg per 24 hours (or micrograms for alfentanil where stated)				Subcutaneous prn opioid Dose in mg every 4 hours injected as required prn NB Alfentanil in lower doses in micrograms				Opioid by patch Dose microgram/hour	
Morphine 24 hour	**Oxycodone 24 hour**	**Diamorphine sc 24 hour**	**Morphine sc 24 hour**	**Oxycodone sc 24 hour**	**Alfentanil sc 24 hour** (500microgram/mL)	**Diamorphine 4 hour**	**Morphine 4 hour**	**Oxycodone 4 hour**	**Alfentanil 2 to 4 hour** (500microgram/mL)	**Fentanyl** normally change every 72 hours	**Buprenorphine** B=Butrans change 7 days T = Transtec change 96 hrs (4 days)
	Calculated by dividing 24 hour oral morphine dose by 2	Calculated by dividing oral morphine dose by 3	Calculated by dividing oral morphine dose by 2	Calculated by dividing oral oxycodone dose by 2	Calculated by dividing 24 hour oral morphine dose by 30	Prn dose is one sixth (1/6th) of 24 hour subcutaneous (sc) syringe driver dose plus opioid patches if in situ. NB *Alfentanil injection is short acting. Maximum 6 prn doses in 24 hours. If require more seek help*				Conversions use UK SPC	
20	10	5	10	5	500mcg	1	2	1	100mcg	(6)	B 10
45	20	15	20	10	1500mcg	2	3	2	250mcg	12	B 20
90	45	30	45	20	3mg	5	7	3	500mcg	25	T 35
140	70	45	70	35	4500mcg	8	10	5	750mcg	37	T 52.5
180	90	60	90	45	6mg	10	15	8	1mg	50	T 70
230	115	75	115	60	7500mcg	12	20	10	1.25mg	62	T 70 + 35
270	140	90	140	70	9mg	15	25	10	1.5mg	75	T70 + 52.5
360	180	120	180	90	12mg	20	30	15	2mg	100	T 140
450	225	150	225	110	15mg	25	35	20	2.5mg	125	-
540	270	180	270	135	18mg	30	45	20	3mg	150	-
630	315	210	315	160	21mg	35	50	25	3.5mg	175	-
720	360	240	360	180	24mg	40	60	30	4mg	200	-

Equivalent doses if converting from oral to sc opioid

Calculation of breakthrough/ rescue / prn doses

Oral prn doses:
- Morphine or Oxycodone: 1/6th of 24 hour oral dose

Subcutaneous:
- Morphine & Oxycodone: 1/6th of 24 hour sc syringe driver (SD) dose
- Alfentanil: 1/6th of 24 hour sc SD dose
  - Short action of up to 2 hours
  - Seek help If reach maximum of 6 prn doses in 24 hours

(For ease of administration, opioid doses over 10mg, prescribe to nearest 5mg)

Renal failure/impairment GFR<30mL/min: Morphine/Diamorphine metabolites accumulate and should be avoided.
- **Fentanyl patch** if pain is stable.
- **Oxycodone** orally or by infusion if mild renal impairment
- If patient is dying & on a fentanyl or buprenorphine patch top up with appropriate sc **oxycodone** or **alfentanil** dose & if necessary, add into syringe driver as per renal guidance
- **If GFR<15mL/min and unable to tolerate oxycodone use alfentanil sc**

If unsure please seek help from palliative care

Fentanyl and buprenorphine patches in the dying/moribund patient
- **Continue fentanyl and buprenorphine patches in these patients.**
  - Remember to change the patch(es) as occasionally this is forgotten!
  - Fentanyl patches are more potent than you may think

If pain occurs whilst patch in situ
- Prescribe 4 hourly prn doses of subcutaneous (sc) morphine unless contraindicated.
- Use an alternative sc opioid e.g. **alfentanil** or **oxycodone** in patients with
  - **poor renal function**,
  - morphine intolerance
  - where morphine is contraindicated
- **Consult pink table when prescribing 4 hourly prn subcutaneous opioids**

Adding a syringe driver (SD) to a fentanyl or buprenorphine patch
If 2 or more rescue/ prn doses are needed in 24 hours, start a syringe driver with appropriate opioid and continue patch(es). The opioid dose in the SD should equal the total prn doses given in the previous 24 hours up to a maximum of 50% of the existing regular opioid dose. Providing the pain is opioid sensitive continue to give prn sc opioid dose and review SD dose daily.
*E.g. Patient on 50 micrograms/hour fentanyl patch, unable to take prn oral opioid and in last days of life. Keep patch on. **Use appropriate opioid for situation or care setting.** If 2 extra doses of 15 mg sc morphine are required over the previous 24 hours, the initial syringe driver prescription will be morphine 30mg/24 hour. **Remember** to look at the **dose of the patch and the dose in the syringe driver** to work out the **new** opioid breakthrough dose **each time a change is made**.*
Always use the chart above to help calculate the correct doses.

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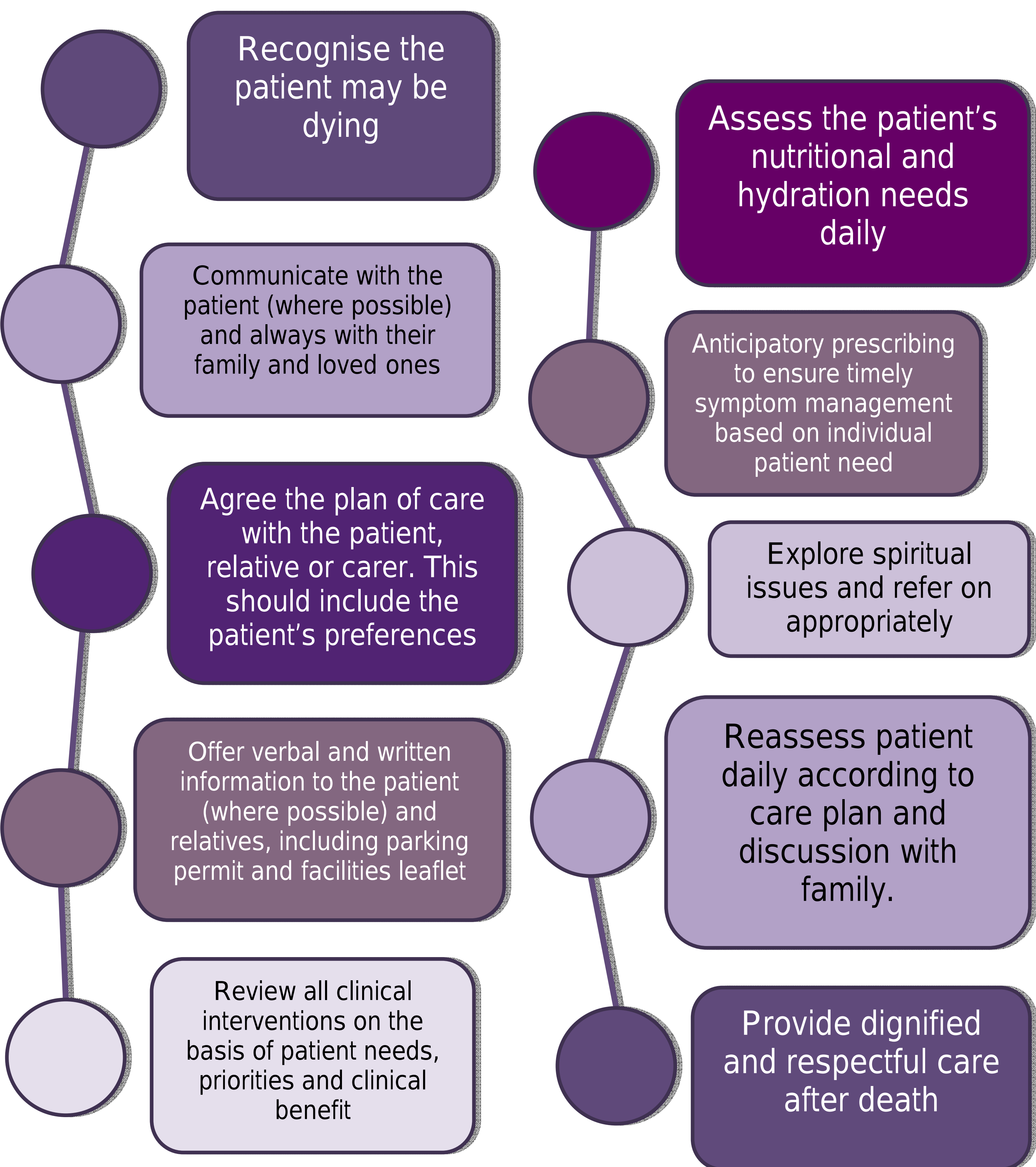
First name: Surname:
DOB: Hosp No:
NHS No:

Caring for patients in the last hours or days of life: a ten point plan



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BMJ John Ellershaw

First name: Surname:
DOB: Hosp No:
NHS No:

Guidance for prescribing anticipatory medicines subcutaneously

If your patient has renal failure look at the cautions in red

Drug	Use	Stat dose sc	24 hours sc dose in syringe driver (SD)	Usual max dose in 24 hours (prn + SD)
Medication for nausea and vomiting				
CYCLIZINE 50mg in 1mL	Centrally acting on vomiting centre. Good for nausea associated with bowel obstruction or increased intracranial pressure Dilute with water **Note** Dose reduction may be necessary in renal, cardiac or liver failure e.g. 25mg	50mg (25mg in patients with renal/heart/ liver failure.) ***Do not use if patient has two or more of above risk factors***	100 to 150mg (75 to 100mg in renal/heart/liver failure)	150mg (75 to 100mg in renal/heart/liver failure)
HALOPERIDOL 5mg in 1mL	Good for chemically induced nausea	1mg May need lower dose in elderly/renal failure 500microgram	1 to 3mg	5mg
METOCLOPRAMIDE 10mg in 2mL NB MHRA caution	Antiemetic action 1. Prokinetic (accelerates GI transit) 2. Centrally acting on chemo-receptor trigger zone (CTZ), blocking transmission to vomiting centre	10mg (5 to 10mg)	30 to 60mg (30mg in renal failure)	120mg (30mg in renal failure)
LEVOMEPROMAZINE 25mg in 1mL	Broad spectrum antiemetic, works on chemo-receptor trigger zone (CTZ) and vomiting centre (at lower doses) Dilute with sodium chloride 0.9% when used alone	5 to 6.25mg	5 to 12.5mg	25mg If require higher doses consult palliative care
Medication for agitation				
MIDAZOLAM 10mg in 2mL	Sedative/anxiolytic (terminal agitation). Also anticonvulsant and muscle relaxant	2 to 5mg Always start low *For major bleeds use 10mg*	5 to 60mg (30mg in renal failure) *Start with lower dose & titrate*	60mg (30mg in renal failure)
LEVOMEPROMAZINE 25mg in 1mL	Antipsychotic used for terminal agitation (2nd line to midazolam)	6.25 to 12.5mg *Start with lower dose & titrate*	6.25 to 50mg *Seek help with higher doses*	200mg (25mg to 50mg in renal failure)
Medication for respiratory secretions				
HYOSCINE BUTYLBROMIDE 20mg in 1mL	Antisecretory - useful in reducing respiratory tract secretions. Has antispasmodic properties May precipitate when mixed with **cyclizine** or **haloperidol** **Less sedating than HYOSCINE HYDROBROMIDE as does not cross the blood brain barrier**	20mg	40 to 120mg	240mg
GLYCOPYRRONIUM 200microgram in 1mL	Antisecretory - useful in reducing respiratory tract secretions Also has antispasmodic properties	200microgram (100microgram)	400 to1200 microgram (1.2mg) (200 to 600 microgram)	1200 micrograms (1.2mg) (600 microgram in renal failure)

Section 1. Decision making process

There are no precise ways of telling accurately when a patient is in the last days of life and it can sometimes be difficult to diagnose dying. For this reason, it is important to take into consideration as much information as possible about the patient's background and current situation. This uncertainty must be communicated to patients and /or families, while being as precise and open and transparent as possible.

Where a member of the MDT (clinical nurse specialist (CNS), doctor in training, nurse in a community setting) recognises that a patient may be dying, this clinical diagnosis/assessment **must be discussed** with the *__senior medical professional__ caring for the patient**.** They will have robust knowledge of the treatment options available and the likely reversibility of the patient's deteriorating condition.

There **must** be agreement from the most ***senior medical professional*** that the patient may be dying.
The name of the *__senior medical professional__ with whom this decision has been discussed should be **recorded and signed**. See section 1, **page 6.**
This must be **countersigned** by a **Consultant or GP** within **48 hours** (weekdays) **and 72 hours** (weekends).

senior medical professional *in hospital is a consultant (if no consultant available ST3 or above).*
In community it will be a GP.

The care plan for the last days of life can only commence once this discussion has been documented

Such a key clinical decision should not ordinarily take place out of hours unless it is unavoidable, urgent and clearly in the best interests of the patient and only where there is access to senior medical review.
To avoid such a situation arising there should be **clear plans** regarding the **ceiling of escalation** of medical care in the event of further deterioration in the patient's condition which

- **must be in place** by the **end of the day** and at the **end of the week**.
- **are agreed by the Consultant or GP**.
- **are clearly communicated to the patient and family/informal carers** in terms that are appropriate for their information needs.

Regular review and assessment of the patient

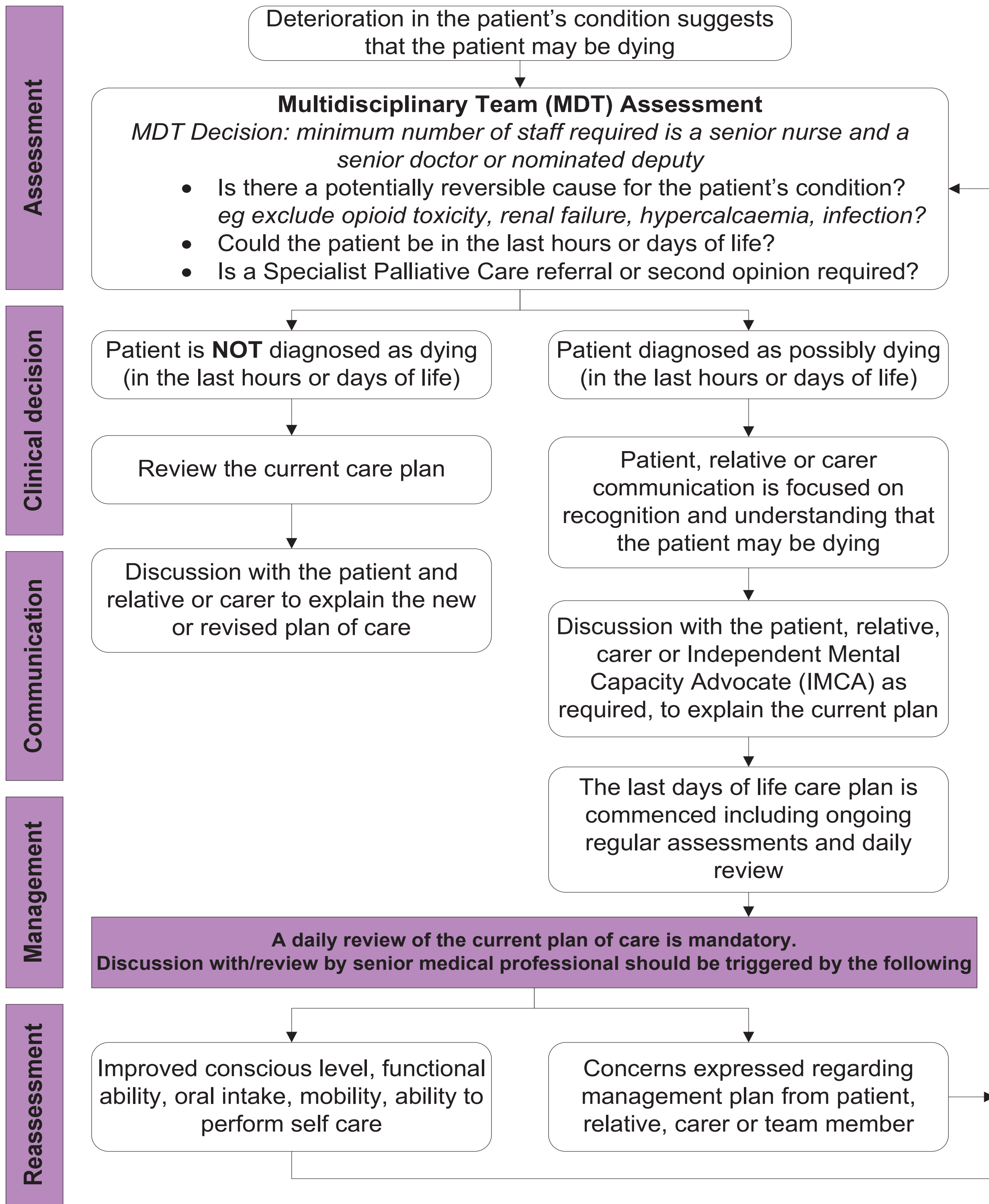
The consultant or GP takes full clinical responsibility for ensuring regular review of the patient and decision to continue the last days of life care plan.
In hospital the medical review may be delegated to a member of the medical team.
In community the district nurse will often coordinate care after the decision making process and all the section 1 paperwork has been completed.

Deciding if a patient may be in the last days of life

The decision should take into account the following:

- Has the patient been diagnosed with an irreversible, life threatening illness of any aetiology?
- Have reversible causes for the patient's current deterioration been considered and appropriately managed? e.g. *hypercalcaemia, sepsis, renal failure, opioid toxicity*
- Has the patient's condition been deteriorating on a daily basis despite all appropriate active and supportive treatment?
- Has the ceiling of care been clearly defined? e.g. would HDU/ICU be appropriate?
- Has cardiopulmonary resuscitation been discussed and been deemed inappropriate for the patient?
- Has the patient or treating team decided to withdraw from active treatment?

Algorithm – Diagnosing the patient may be dying & supporting care in the last days of life



Always remember that the Specialist Palliative Care Team is available for advice and support, especially if symptom control is difficult and/or if there are difficult communication issues

Section 1 Decision making. Senior medical professional to complete (Consultant / GP)

Communication

1.1 Is the patient able to take a full and active part in communication about their care? **Yes** **No**
If No is the patient unconscious? **Yes** **No**

First language:	1st language not English, interpreter required? **Yes** **No** If interpreter required Contact No:

1.2 Have barriers that have the potential to prevent communication been assessed? **Yes** **No**
Consider: *Hearing, vision, speech, learning disabilities, dementia (use of assessment tools), neurological conditions and confusion. The relative or carer may have information about how the patient may express distress, if the patient is unable to articulate their own concerns. Document any important information below.*

Capacity

1.3 Does patient have **full capacity** to make own decisions about their treatment at this time? **Yes** **No**

If **No** to what extent is the capacity limited?
Please specify the limits of ability to make an informed decision at this time. Refer to the MCA 2007

In the event of limited or no capacity does the patient have		
1.4 an **advance care plan**?	**Yes**	**No**
1.5 a valid **advance decision to refuse treatment** (ADRT)?	**Yes**	**No**
1.6 a **valid Lasting Power of Attorney for health matters?** If **Yes** please write Name: Contact details:	**Yes**	**No**

If a patient is unconscious/does not have capacity and there are no relatives, carers or healthcare professionals who know the patient well enough to guide clinical staff in making best interest decisions, consider the appointment of an ***Independent Mental Capacity Advocate (IMCA)***

Wish

1.7 Has the patient expressed a wish for **organ/tissue donation**? *If Yes make a note in section 3.2* **Yes** **No**

1.8 Has the patient expressed a preferred place of death? If yes please specify **Yes** **No**

Home	Hospital	Hospice	Other e.g. care home	unknown

Contacts

1.9 Agreed Contacts for the patient

1st contact name:		2nd contact name:	
Relationship to the patient:		Relationship to the patient:	
Tel No:		Tel No:	
Mobile No:		Mobile No:	
When to contact: Staying with patient overnight Not at night time At any time:		**When to contact:** Staying with patient overnight Not at night time At any time:	

Section 1

Rationale for deciding that the patient may be in the last days of life and record of significant conversations

Professional leading the decision making process to complete this section

*The clinician should discuss that the patient **may now be dying** and establish with the patient (if appropriate) and family's understanding of the clinical situation. When making decisions about the patient's care it is important to identify what aspects of care are important to the patient/family so they can be discussed in detail and incorporated if possible into the patient's individual care plan.*

The following areas should be discussed using clear and unambiguous terminology

- *patient and family concerns around the dying process*
- *likely course of events and prognosis*
- *ceiling of care*
- *artificial hydration and nutrition, if appropriate*
- *DNACPR*
- *withdrawal or commencement of treatment*
- *alteration in medications*
- *use of a syringe driver*

If the family or carers do not accept that the patient may be dying following clear explanation a second opinion must be considered.

List names of family / carers present:	**List names of staff present:**
Diagnosis:	**Co-morbidities:** **Allergies:**

Documentation of conversation with patient and family

If more space required write in continuation sheets page 25 to 29

Time:	Name (Print):	Signature:
Date:	Designated role:	Contact No:

Senior medical professional that above decision has been discussed with (if applicable)	

The above decision, if signed by a training doctor, community nurse/ district nurse or clinical nurse specialist (CNS) must be agreed at the time of commencement by the most senior medical professional responsible for the patient's care e.g. Consultant or GP.

The decision to continue the plan must be ***Countersigned within 48 hours on weekday or 72 hours at weekends*

Time:	Name (Print):	** Countersignature of senior medical professional	
Date:	Consultant	GP	Contact No:

Following the discussion with patient and family that patient is now entering the dying phase the care should be **documented,** from now on**, in the care plan for the last days of life. Doctors complete Section 1**

If care plan has been discontinued please record the following

Date:		Signature:	
Time:		Name (print):	Designation/ Grade:
Reason why Discontinued?		Is patient aware care plan discontinued? Yes No Is family/carer aware plan discontinued? Yes No	

File in notes and continue with usual medical records

Section 1. Initial assessment (Doctor)

Clinically assisted (artificial) hydration and nutrition

A reduced need for fluid and food occurs as part of the normal dying process.
For many patients, continuing to support oral intake and providing excellent mouth care is sufficient to keep them comfortable.
For others, if symptoms of **thirst** persist, a trial of parenteral fluids may be indicated.
The least invasive route for this is subcutaneously and 1 litre of 0.9% sodium chloride may be administered over 12 hours. See subcutaneous fluid policy.
Regular assessment and consideration of the benefits and burdens of fluids should take place and the perceptions of the patient family/carers should be taken into account when making decisions.
A reduction in the rate and volume of food and fluid for those already on feeding regimes should be considered in the final days of life.
It is important that discussions around nutrition and hydration take place with patients and their carers/families. Record relevant discussions below or on page 5 to 6 in decision making document.
If any significant changes occur in the patient's condition document in the continuation sheets.

1.10: Clinical assisted (artificial) hydration (CAH)

If the patient's thirst is persistent see text in above section

Please document discussions and decision about the use of CAH below or on pages 5 to 6

1.11: Clinical assisted (artificial) nutrition (CAN)

Please document discussions and decision about the use of CAN below or on pages 5 to 6

1.12: Is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place? Yes No

If No following discussion complete the **regional DNACPR form**

Please document discussions and decision about CPR below or on pages 5 to 6

1.13: Does the patient have an Implantable Cardioverter Defibrillator (ICD) in place? Yes No

Cardiology team contacted: Date contacted:
What is agreed plan?
Document discussion has taken place with patient/family?

If ICD in place has it been deactivated? ***Yes*** **No**
If No, and decision is for ICD to be deactivated contact cardiorespiratory technicians to deactivate*
See policy *Date deactivated

Nutrition and Hydration Assessment

DNACPR

ICD

Interventions

1.14:The patient's need for current intervention has been reviewed by the multi-professional team

	Continued	Discontinued	Commenced	NA
Routine blood tests				
Intravenous antibiotics				
Blood glucose monitoring				
Recording routine vital signs, Pulse, BP, temperature, O_2 sats				
Oxygen therapy				

Record any additional interventional information below or on pages 5 to 6

Anticipatory drugs

1.15: The multi-professional team has assessed the patient and has prescribed PRN medication on the patient's need to support symptoms which may develop in the last hours or days of life. (refer to **Section 4** for Symptom Control *Always consider the patient's GFR when prescribing.*)

Anticipatory prescribing will ensure that there is no delay in responding to a symptom if it occurs in the last days of life. ***It is good practice to prescribe PRN medication for the following, where clinical appropriate.***

Pain **Agitation** **Respiratory tract secretions**

Nausea/Vomiting **Dyspnoea** **Seizures** ***Diabetes** *pg 34

Rationalise

1.16 The multi-professional team has assessed the patient's medication and discontinued any non essential medication not contributing to the patient's comfort. E.g. anti-hypertensives, statins,

Please document discussions and decisions made below or on pages 5 to 6

Syringe driver availability

1.17: A syringe driver is available if required
A syringe driver prescription chart should be used with all syringe drivers. See local policy.

Not all patients who are dying will require a syringe driver.
If it is considered necessary that medication is delivered using a syringe driver, **it is important that the patient and family are informed of the rationale for its use.**
Whilst there should not be a significant delay in commencing required medication, all reasonable efforts should be made to discuss this with the carer/family before the syringe driver is started.
Any medication given via a syringe driver / continuous subcutaneous infusion (CSCI) should be appropriate to the symptom it is prescribed to treat and in a dose that is proportional to the severity of that symptom. (*Consult symptom control guidelines in Section 4*) ***Record relevant discussions below or on pages 5 to 6***

If advice is required contact End of Life Care Educator / Palliative Care Team.
OOH advice St Leonards Hospice, York or St Catherine's Hospice, Scarborough (Details on front page)

Individualised care plan for the last days of life

Cross care setting document

After the decision making document is completed and last days of life care plan has been commenced ***do not write in the medical notes.*** **except for specialist nursing care plans**

If the patient's condition improves and the care plan is no longer required discontinue it and document on page 6. Resume usual documentation in the medical and nursing records. The care plan must be filed in the medical records.

Section	Contents	Pages
2.	**Care plan** Initial assessment nurses Initial and daily ongoing assessment	9 11 12
3.	Care after Death	31
4.	Symptom Control Guidelines	33

Name of Responsible Consultant: (hospital/ hospice)

Name of Responsible GP: (home/ care home)

Name of Responsible Nurse:

All personnel using this care plan must write details here				
Name (print)	Full signature	Initials	Professional title	Date

Section 2 Initial assessment (Nurses)

2.1: The patient's skin integrity is assessed

Repositioning frequency should be determined by skin inspection, assessment & the patient's needs. The aim is to prevent pressure ulcers or further deterioration if a pressure ulcer is present.

Use specialist skin care plan if required.

Record the plan of care on the continuation and communication sheets in **section 2** where appropriate.

2.2: The patient is given the opportunity to discuss what is important to them at this time, e.g. their wishes, feelings, faith, beliefs and values.

Patient may be anxious for self or others. Consider religious and cultural needs.

Was patient offered the opportunity to discuss the above?	**Unconscious**	**Yes**	**No**

Religious tradition identified, please specify:

Document specific cultural or faith based requirements (denomination/faith/community)

Was chaplaincy support offered **Yes** **No**

If No, give reason:

In-house support	Name:	Bleep /Tel No:	Date/time:
External support	Name:	Tel No:	Date/time:

2.3: The relative or carer is given the opportunity to discuss what is important to them at this time, e.g. their wishes, feelings, faith, beliefs and values. **Yes** **No**

Did the relative or carer take the opportunity to discuss the above? **Yes** **No**

2.4: Supporting Information leaflet re last days of life given to relative or carer N/A Yes No

Found at the front of document

2.5: The relative/carer has been informed of the facilities available to them. N/A Yes No

Facilities include: car parking permit, toilet, bathroom facilities, beverages, payphone & accommodation.

A facilities leaflet has been offered Concessionary Car Parking permit given

2.6: GP practice has been notified that the patient may be dying Yes No

(Hospital / hospice / care home only)

GP to be informed that the patient may be dying. Message may be left with receptionist by ward clerk / district nurse / hospice / care home staff.

2.7: The patient details have been added onto patient list, care plan for last days of life on CPD (Hospital/community hospital) N/A Yes No

Nurse to sign below on completion of pages 11,12 & 14 of initial assessment in Section 2

Name of nurse (print):	**Grade:**
Signature:	**Ward** if applicable**:**
Date / Time:	

Skin

Spirituality

Facilities

GP

Signatures

Section 2 Initial and ongoing assessment of care PTO for K to R

Day 1 Date: **Record Yes (Y) or No (N) or not applicable N/A**

In hospital/community hospital/hospice, the minimal interval between checks is 4 hours
In community the minimum checking is daily

Assessment A to J	0000	0400	0800	1200	1600	2000
Daily medical review	Doctor please sign					
	Initials of person assessing after each assessment					
A: Is the patient in pain? • Verbalised by the patient if conscious. • Observe for non-verbal cues. • Pain on movement. • Consider need for positional change. • Consider prn analgesia for incident pain.	Y N	Y N	Y N	Y N	Y N	Y N
B: Is the patient agitated? • Signs of delirium, terminal restlessness or distress? (thrashing, plucking, myoclonus) • Exclude reversible causes e.g. retention of urine, faecal impaction, opioid toxicity.	Y N	Y N	Y N	Y N	Y N	Y N
C: Does the patient have respiratory tract secretions? • Consider positional change. • Give explanation to the family	Y N	Y N	Y N	Y N	Y N	Y N
D: Does the patient have nausea? • Verbalised if patient is conscious.	Y N	Y N	Y N	Y N	Y N	Y N
E: Is the patient vomiting? • What is the cause?	Y N	Y N	Y N	Y N	Y N	Y N
F: Is the patient breathless? • Verbalised by patient if conscious, consider positional change. • A fan may be helpful.	Y N	Y N	Y N	Y N	Y N	Y N
G: Does the patient have any urinary problems? • Use of pads, urinary catheter as required.	Y N	Y N	Y N	Y N	Y N	Y N
H: Does the patient have any bowel problems? • Monitor – constipation/diarrhoea. • Monitor skin integrity. • **Bowels last opened: ……………………**	Y N	Y N	Y N	Y N	Y N	Y N
I: Does the patient have any other symptoms? e.g. seizures Record symptoms here…………………………… *If no other symptoms present please circle N/A*	Y N	Y N	Y N	Y N	Y N	Y N
	N/A	N/A	N/A	N/A	N/A	N/A
J : Is the patient's comfort & safety maintained with respect to administration of medication? • If syringe driver in place use a syringe driver chart. *If no medication required please circle N/A*	Y N	Y N	Y N	Y N	Y N	Y N
	N/A	N/A	N/A	N/A	N/A	N/A

Section 2	**Actions**		**Day 1** Date:
Symptom / issue identified	Action Taken (What did you do?)	Outcome (Did this solve the issue?)	
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:

Section 2 Initial and ongoing assessment of care

Day 1 Date: **Record Yes (Y) or No (N) or not applicable NA**

In hospital/community hospital/hospice, the minimal interval between checks is 4 hours
In community the minimum checking is daily

Assessment K to R	0000	0400	0800	1200	1600	2000
All patients to be offered oral fluids and nutrition unless medically contraindicated	Initials of person assessing after each assessment					
K: Has the patient been offered oral fluids and nutrition to support their needs? • Ensure the patient is supported to take oral fluids/ thickened fluids & nutrition for as long as tolerated. o Monitor for signs of aspiration and /or distress.	Y N	Y N	Y N	Y N	Y N	Y N
L: Does the patient have artificial hydration or nutrition in place? • Monitor & review rate/volume. MDT to review appropriateness regularly.	Y N	Y N	Y N	Y N	Y N	Y N
M: Is the patient's mouth moist & clean? • See mouth care policy. • Relative or carer involved in care. • Mouth care tray at the bedside.	Y N	Y N	Y N	Y N	Y N	Y N
N: Is patient's skin integrity maintained? ***If patient has a specialised care plan for wound / skin care continue to use this*** • Assessment, cleansing, positioning, use of special aids (mattress/bed). • Repositioning frequency determined by patient's skin condition.	Y N	Y N	Y N	Y N	Y N	Y N
Waterlow score (WL): *Purat (P) score:* *or equiv score*						
O: Are the patient's personal hygiene needs being met? • Skin care, wash, eye care, change of clothing according to individual needs. • Relative or carer involved in care giving as appropriate.	Y N	Y N	Y N	Y N	Y N	Y N
P: Is the patient receiving their care in a physical environment adjusted to support their individual needs? • Clean environment, sufficient space at bedside. • In hospital is the nurse call bell accessible.	Y N	Y N	Y N	Y N	Y N	Y N
Q: Is the patient's psychological well-being maintained? • In hospital staff being at the bedside can be a sign of support and caring. Use touch if appropriate. • Respectful verbal and non-verbal communication, use of listening skills, information and explanation of care given. • Spiritual/religious/cultural needs to be addressed.	Y N	Y N	Y N	Y N	Y N	Y N
R: Is the well-being of the relative or carer attending the patient being maintained? • Being at the bedside can be a sign of support and caring. • Consider spiritual/religious/cultural needs, expressions may be unfamiliar to the healthcare professional but normal for the relative or carer. • Support of the chaplaincy team may be helpful. • Listen & respond to worries/fears. • Age appropriate advice & information available to parents or carers to support children/adolescents. • Allow the opportunity to talk reminisce.	Y N	Y N	Y N	Y N	Y N	Y N

Section 2	Actions		Day 1
Symptom / issue identified	Action Taken (What did you do?)	Outcome (Did this solve the issue?)	Date:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:

Section 2 Ongoing assessment of care PTO for K to R

Day 2 Date: **Record Yes (Y) or No (N) or not applicable N/A**

In hospital/community hospital/hospice, the minimal interval between checks is 4 hours
In community the minimum checking is daily

Assessment A to J	0000	0400	0800	1200	1600	2000
Daily medical review	Doctor please sign					
	Initials of person assessing after each assessment					
A: Is the patient in pain? • Verbalised by the patient if conscious. • Observe for non-verbal cues. • Pain on movement. • Consider need for positional change. • Consider prn analgesia for incident pain.	Y N	Y N	Y N	Y N	Y N	Y N
B: Is the patient agitated? • Signs of delirium, terminal restlessness or distress? (thrashing, plucking, myoclonus) • Exclude reversible causes e.g. retention of urine, faecal impaction, opioid toxicity.	Y N	Y N	Y N	Y N	Y N	Y N
C: Does the patient have respiratory tract secretions? • Consider positional change. • Give explanation to the family	Y N	Y N	Y N	Y N	Y N	Y N
D: Does the patient have nausea? • Verbalised if patient is conscious.	Y N	Y N	Y N	Y N	Y N	Y N
E: Is the patient vomiting? • What is the cause?	Y N	Y N	Y N	Y N	Y N	Y N
F: Is the patient breathless? • Verbalised by patient if conscious, consider positional change. • A fan may be helpful.	Y N	Y N	Y N	Y N	Y N	Y N
G: Does the patient have any urinary problems? • Use of pads, urinary catheter as required.	Y N	Y N	Y N	Y N	Y N	Y N
H: Does the patient have any bowel problems? • Monitor – constipation/diarrhoea. • Monitor skin integrity. • **Bowels last opened: ....**	Y N	Y N	Y N	Y N	Y N	Y N
I: Does the patient have any other symptoms? e.g. seizures Record symptoms here................................ *If no other symptoms present please circle N/A*	Y N	Y N	Y N	Y N	Y N	Y N
	N/A	N/A	N/A	N/A	N/A	N/A
J : Is the patient's comfort & safety maintained with respect to administration of medication? • If syringe driver in place use a syringe driver chart. *If no medication required please circle N/A*	Y N	Y N	Y N	Y N	Y N	Y N
	N/A	N/A	N/A	N/A	N/A	N/A

Section 2	Actions		Day 2
Symptom / issue identified (What was the issue?)	Action Taken (What did you do?)	Outcome (Did this solve the issue?)	Date:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:

Section 2 Ongoing assessment of care

Day 2 Date: Record Yes (Y) or No (N) or not applicable NA

In hospital/community hospital/hospice, the minimal interval between checks is 4 hours
In community the minimum checking is daily

Assessment K to R	0000	0400	0800	1200	1600	2000
All patients to be offered oral fluids and nutrition unless medically contraindicated	Initials of person assessing after each assessment					
K: Has the patient been offered oral fluids and nutrition to support their needs? • Ensure the patient is supported to take oral fluids/ thickened fluids & nutrition for as long as tolerated. o Monitor for signs of aspiration and /or distress.	Y N	Y N	Y N	Y N	Y N	Y N
L: Does the patient have artificial hydration or nutrition in place? • Monitor & review rate/volume. MDT to review appropriateness regularly.	Y N	Y N	Y N	Y N	Y N	Y N
M: Is the patient's mouth moist & clean? • See mouth care policy. • Relative or carer involved in care. • Mouth care tray at the bedside.	Y N	Y N	Y N	Y N	Y N	Y N
N: Is patient's skin integrity maintained? ***If patient has a specialised care plan for wound / skin care continue to use this*** • Assessment, cleansing, positioning, use of special aids (mattress/bed). • Repositioning frequency determined by patient's skin condition.	Y N	Y N	Y N	Y N	Y N	Y N
Waterlow score (WL): *Purat (P) score: or equiv score*						
O: Are the patient's personal hygiene needs being met? • Skin care, wash, eye care, change of clothing according to individual needs. • Relative or carer involved in care giving as appropriate.	Y N	Y N	Y N	Y N	Y N	Y N
P: Is the patient receiving their care in a physical environment adjusted to support their individual needs? • Clean environment, sufficient space at bedside. • In hospital is the nurse call bell accessible.	Y N	Y N	Y N	Y N	Y N	Y N
Q: Is the patient's psychological well-being maintained? • In hospital staff being at the bedside can be a sign of support and caring. Use touch if appropriate. • Respectful verbal and non-verbal communication, use of listening skills, information and explanation of care given. • Spiritual/religious/cultural needs to be addressed.	Y N	Y N	Y N	Y N	Y N	Y N
R: Is the well-being of the relative or carer attending the patient being maintained? • Being at the bedside can be a sign of support and caring. • Consider spiritual/religious/cultural needs, expressions may be unfamiliar to the healthcare professional but normal for the relative or carer. • Support of the chaplaincy team may be helpful. • Listen & respond to worries/fears. • Age appropriate advice & information available to parents or carers to support children/adolescents. • Allow the opportunity to talk reminisce.	Y N	Y N	Y N	Y N	Y N	Y N

Section 2	Actions		Day 2
Symptom / issue identified (What was the issue?)	Action Taken (What did you do?)	Outcome (Did this solve the issue?)	Date:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:

Section 2 Ongoing assessment of care PTO for K to R

Day 3 Date: **Record Yes (Y) or No (N) or not applicable N/A**

In hospital/community hospital/hospice, the minimal interval between checks is 4 hours
In community the minimum checking is daily

Assessment A to J	0000	0400	0800	1200	1600	2000
Daily medical review	Doctor please sign					
	Initials of person assessing after each assessment					
A: Is the patient in pain? • Verbalised by the patient if conscious. • Observe for non-verbal cues. • Pain on movement. • Consider need for positional change. • Consider prn analgesia for incident pain.	Y N	Y N	Y N	Y N	Y N	Y N
B: Is the patient agitated? • Signs of delirium, terminal restlessness or distress? (thrashing, plucking, myoclonus) • Exclude reversible causes e.g. retention of urine, faecal impaction, opioid toxicity.	Y N	Y N	Y N	Y N	Y N	Y N
C: Does the patient have respiratory tract secretions? • Consider positional change. • Give explanation to the family	Y N	Y N	Y N	Y N	Y N	Y N
D: Does the patient have nausea? • Verbalised if patient is conscious.	Y N	Y N	Y N	Y N	Y N	Y N
E: Is the patient vomiting? • What is the cause?	Y N	Y N	Y N	Y N	Y N	Y N
F: Is the patient breathless? • Verbalised by patient if conscious, consider positional change. • A fan may be helpful.	Y N	Y N	Y N	Y N	Y N	Y N
G: Does the patient have any urinary problems? • Use of pads, urinary catheter as required.	Y N	Y N	Y N	Y N	Y N	Y N
H: Does the patient have any bowel problems? • Monitor – constipation/diarrhoea. • Monitor skin integrity. • **Bowels last opened: ....**	Y N	Y N	Y N	Y N	Y N	Y N
I: Does the patient have any other symptoms? e.g. seizures Record symptoms here................................ *If no other symptoms present please circle N/A*	Y N	Y N	Y N	Y N	Y N	Y N
	N/A	N/A	N/A	N/A	N/A	N/A
J : Is the patient's comfort & safety maintained with respect to administration of medication? • If syringe driver in place use a syringe driver chart. *If no medication required please circle N/A*	Y N	Y N	Y N	Y N	Y N	Y N
	N/A	N/A	N/A	N/A	N/A	N/A

Section 2	Actions		Day 3
What is the symptom?	Action Taken (What did you do?)	Outcome (Did this resolve the issue?)	Date:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:

Section 2 Ongoing assessment of care

Day 3 Date: **Record Yes (Y) or No (N) or not applicable NA**

In hospital/community hospital/hospice, the minimal interval between checks is 4 hours
In community the minimum checking is daily

Goals K to R	0000	0400	0800	1200	1600	2000
All patients to be offered oral fluids and nutrition unless medically contraindicated	Initials of person assessing after each assessment					
K: Has the patient been offered oral fluids and nutrition to support their needs? • Ensure the patient is supported to take oral fluids/ thickened fluids & nutrition for as long as tolerated. o Monitor for signs of aspiration and /or distress.	Y N	Y N	Y N	Y N	Y N	Y N
L: Does the patient have artificial hydration or nutrition in place? • Monitor & review rate/volume. MDT to review appropriateness regularly.	Y N	Y N	Y N	Y N	Y N	Y N
M: Is the patient's mouth moist & clean? • See mouth care policy. • Relative or carer involved in care. • Mouth care tray at the bedside.	Y N	Y N	Y N	Y N	Y N	Y N
N: Is patient's skin integrity maintained? ***If patient has a specialised care plan for wound / skin care continue to use this*** • Assessment, cleansing, positioning, use of special aids (mattress/bed). • Repositioning frequency determined by patient's skin condition.	Y N	Y N	Y N	Y N	Y N	Y N
Waterlow score (WL): *Purat (P) score:* *or equiv score*						
O: Are the patient's personal hygiene needs being met? • Skin care, wash, eye care, change of clothing according to individual needs. • Relative or carer involved in care giving as appropriate.	Y N	Y N	Y N	Y N	Y N	Y N
P: Is the patient receiving their care in a physical environment adjusted to support their individual needs? • Clean environment, sufficient space at bedside. • In hospital is the nurse call bell accessible.	Y N	Y N	Y N	Y N	Y N	Y N
Q: Is the patient's psychological well-being maintained? • In hospital staff being at the bedside can be a sign of support and caring. Use touch if appropriate. • Respectful verbal and non-verbal communication, use of listening skills, information and explanation of care given. • Spiritual/religious/cultural needs to be addressed.	Y N	Y N	Y N	Y N	Y N	Y N
R: Is the well-being of the relative or carer attending the patient being maintained? • Being at the bedside can be a sign of support and caring. • Consider spiritual/religious/cultural needs, expressions may be unfamiliar to the healthcare professional but normal for the relative or carer. • Support of the chaplaincy team may be helpful. • Listen & respond to worries/fears. • Age appropriate advice & information available to parents or carers to support children/adolescents. • Allow the opportunity to talk reminisce.	Y N	Y N	Y N	Y N	Y N	Y N

Section 3 Actions			Day 3
Symptom / issue identified (What was the issue?)	Action Taken (What did you do?)	Outcome (Did this solve the issue?)	Date:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:
Assessment:			Time: Signature:

Medical review

Insert additional documentation pages here from day 4 onward

	Additional pages needed	Date and time of medical review	Name and signature of senior clinician or nominated deputy
Day 2 Daily medical review	No		
Day 3 Daily medical review	No		
Day 4 Daily medical review	☐		
Day 5 Daily medical review	☐		
Day 6 Daily medical review	☐		
Day 7 Daily medical review	☐		
Day 8 Daily medical review	☐		
Day 9 Daily medical review	☐		
Day 10 Daily medical review	☐		
Day 11 Daily medical review	☐		
Day 12 Daily medical review	☐		
Day 13 Daily medical review	☐		
Day 14 Daily medical review	☐		

Section 2	Continuation and Communication sheets **Record outstanding or significant issues from section 1 and 2** Record significant events, MDTs, ward rounds, conversations with family, opioid calculations, and visit by community staff or specialist teams e.g. palliative care.
Date / Time	Please write designation, date, time and signature after each entry

Section 2	**Continuation and Communication sheets** Record significant events, MDTs, ward rounds, conversations with family, opioid calculations, and visit by community staff or specialist teams e.g. palliative care.
Date / Time	Please write designation, date, time and signature after each entry

Section 2	**Continuation and Communication sheets** **Record outstanding or significant issues from section 1 and 2** Record significant events, MDTs, ward rounds, conversations with family, opioid calculations, and visit by community staff or specialist teams e.g. palliative care.
Date / Time	Please write designation, date, time and signature after each entry

Section 2	**Continuation and Communication sheets** Record significant events, MDTs, ward rounds, conversations with family, opioid calculations, and visit by community staff or specialist teams e.g. palliative care.
Date / Time	Please write designation, date, time and signature after each entry

Section 2	**Continuation and Communication sheets** **Record outstanding or significant issues from section 1 and 2** Record significant events, MDTs, ward rounds, conversations with family, opioid calculations, and visit by community staff or specialist teams e.g. palliative care.
Date / Time	Please write designation, date, time and signature after each entry

Section 3: Documentation after death

In hospital and community hospitals this section must be completed by the doctor, nursing staff and ward clerk.

In community complete as much as possible.

All sections must be signed and dated.

(see pages 31 to 32)

Section 3 Care after death (doctor or accredited nurse to complete)

Pronouncement of Death

Patient's Name:	Persons present at death (Print):
Date of death:	Time of death:

Patient is unresponsive ☐
No respiratory effort ☐
No cardiac output ☐
Pupils not reacting to light ☐

Time of verification of death:

Signature:	Print Name:

Pronouncement of death

Death Certified by (Medical staff to complete)

Print Name:	
Signature:	
Bleep/Contact No:	

Document cause of death for purpose of certification (for hospital use only)

Ia)

Ib)

Ic)

II)

Death certification

Burial Is there an infection hazard?	**Yes** ☐	**No** ☐	**If Yes inform mortuary staff**
If death certificate not issued **Has coroner been informed?**	**Yes** ☐	**No** ☐	
Post-mortem required?	**Yes** ☐	**No** ☐	

PM

Cremation forms

Are Cremation forms required?	**Yes** ☐	**No** ☐	
If Yes does the patient have an implantable device?			
No Device ☐	Intrathecal pump / Spinal stimulator ☐	Pacemaker/ICD ☐	Other ☐
If Yes has it been removed?	**Yes** ☐	**No** ☐	**If No inform mortuary staff**
Is there an infection hazard?	**Yes** ☐	**No** ☐	**If Yes inform mortuary staff**

Cremation forms completed by (medical staff to complete in hospital)

Print Name:	Date:
Signature:	Time:
Additional Notes if needed	

Cremation

Patient Care, Dignity and Bereavement

Section 3 Care after death (nurse to complete)

3.1: Care after death is to be undertaken according to policy and procedure

The patient is to be treated with dignity and respect whilst care after death is undertaken.
Universal precautions and local policy and procedures including infection risk must be adhered to.
Cultural, spiritual and religious requirements should be met.
Organisational policy should be followed for

- the management of implantable device, where appropriate.
- the management and storage of patient's valuables and belongings (hospital/community hospitals).

3.2: Following a patient's death please ensure that the relatives / carers

- have the opportunity to discuss organ donation if appropriate. See front page for tel Nos
- have discussions, if appropriate, about
  - o viewing the body.
  - o referral to the coroner and requirement of a post mortem.
  - o removal of any implantable device.
- are given a clear explanation and written information about what to do next regarding collecting the death certificate and registering the death.
- have information on how to contact the bereavement services.
- have been given information on child bereavement services, where appropriate.

Bereavement booklet(s) given?
Statistory information → **Statutory information** **Yes** ☐ **No** ☐ **Local information** **Yes** ☐ **No** ☐

Print Name:	**Date:**
Signature:	**Time:**

Organisational information

Completion determined by care setting e.g.
Hospital ward clerks / Community district nurses / care home staff or hospice staff

3.3: Has the GP been notified of the patient's death? NA ☐ Yes ☐ No ☐
Date:

The primary health care team/GP may have known this patient very well and other relatives or carers may be registered with the same GP. **Telephone or fax the GP practice**
Name of person informing GP practice:

Name of person in practice that has been informed:

3.4: Has the patient's death been communicated to all appropriate services across the organisation? Yes ☐ No ☐

Doing so reduces the likelihood that the family/ carers will have to deal with unnecessary enquiries and these professionals can provide a valuable source of support for families.

District nurse ☐ Macmillan nurse ☐ Community matron ☐ Palliative care team (s) ☐
Social care ☐ Care agencies ☐ Other ☐ please state

3.5: The patient's death is entered on to CPD (hospital/community hospital) N/A ☐ Yes ☐ No ☐

Print Name:	**Date:**
Signature:	**Time:**

Section 4 Principles of symptom management in last days of life

These principles are applicable to the care of patients who may be dying from any cause

Recognise that death is approaching

Studies have found that dying patients will manifest some or all of the following:

- Profound weakness - usually bedbound
- Drowsy or reduced cognition - semi-comatose
- Diminished intake of food and fluids - only able to take sips of fluid
- Difficulty in swallowing medication - no longer able to take tablets

Treatment of symptoms

The prime aim of all treatment at this stage is the control of symptoms current and potential.

- **Discontinue any medication which is not essential**
- **Prescribe medication necessary to control current distressing symptoms**
- **All patients who may be dying would benefit from having ANTICIPATORY subcutaneous medication prescribed JUST IN CASE distressing symptoms develop**
- **All medication needs should be reviewed every 24 hours**
- **Prn medications may be administered via a Saf -T- intima line**
- **If two or more doses of prn medication have been required, then consider the use of a syringe driver for continuous subcutaneous infusion (CSCI)**

The most frequently reported symptoms are:-

- Pain
- Nausea / Vomiting
- Excessive secretions / Noisy breathing
- Agitation / Restlessness
- Dyspnoea

Opioid choice and syringe drivers

Morphine sulphate is the injectable opioid of choice in the majority of patients.
Alternative opioids (when morphine is not tolerated or in patients with severe renal failure e.g. GFR< 30mL /min) include oxycodone or alfentanil.

Both morphine sulphate and oxycodone are compatible with all the medications that are recommended in the following guidelines (cyclizine, haloperidol, levomepromazine, hyoscine butylbromide, glycopyrronium, metoclopramide and midazolam).
Incompatibility may occur when higher doses of oxycodone >150mg are mixed with cyclizine.
Alfentanil is compatible with all the above medications that are recommended, **with exception of cyclizine.**

Use either water for injection or sodium chloride 0.9 % as the diluent, **unless mixing with cyclizine**, when water for injection must be used.
With the introduction of the T34 McKinley syringe drivers use a 20mL syringe as standard and if a larger volume is required use a 30mL syringe.

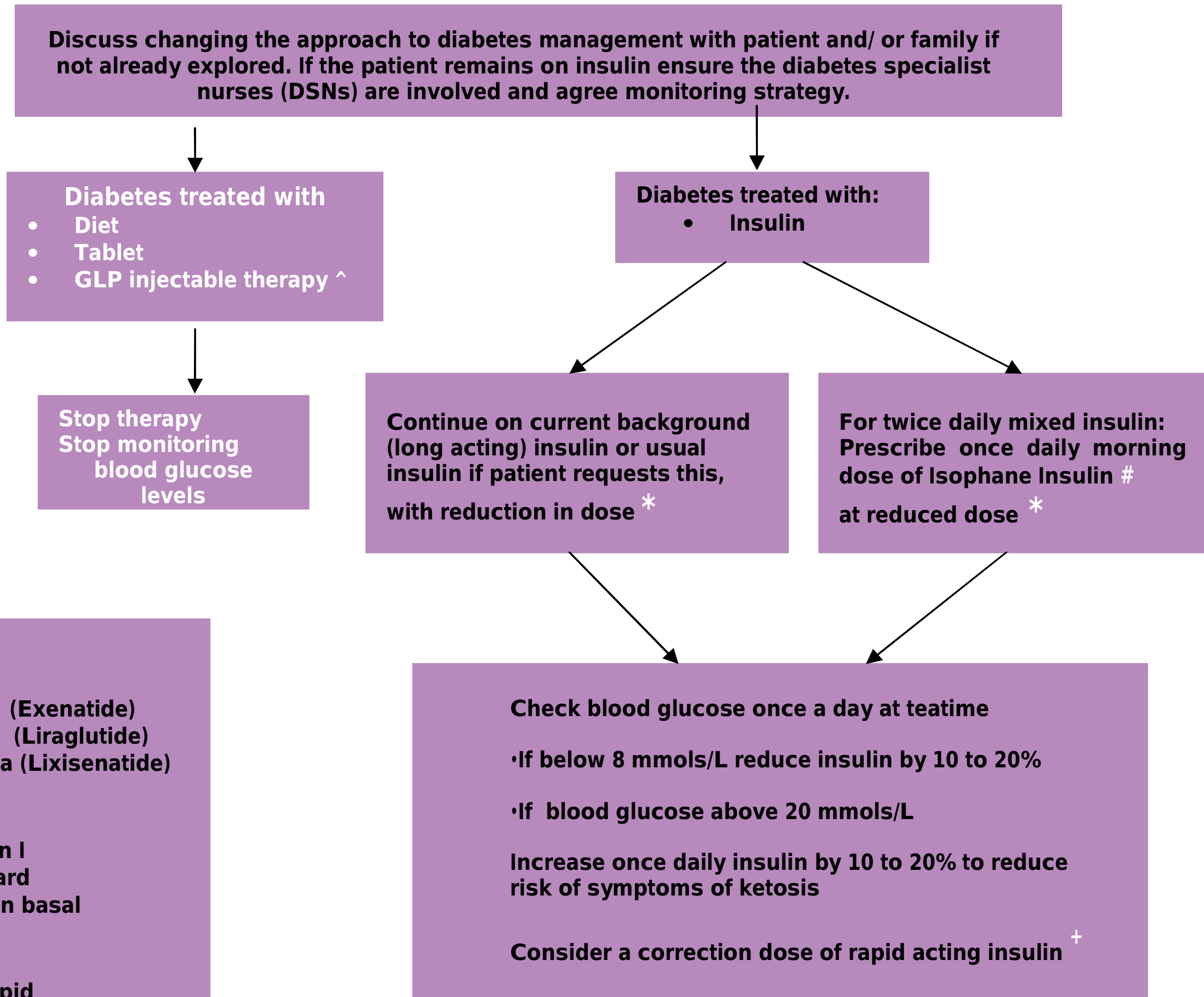
For information on the usual doses of drugs used in a syringe driver see inside of back cover.
For guidance on converting between opioids see the coloured opioid conversion chart.
For further information on compatibility in a syringe driver contact:

York Hospital enquiries **York Medicines Information**	**Scarborough Hospital enquiries** **Scarborough Medicines Information**	**GP enquiries** **Newcastle Medicines Information**
01904 725960	**01723 385170**	**0191 2824631**

The algorithms will support you in your management of the most frequently reported symptoms

Algorithm for an End of Life Diabetes Care Management Strategy is given below:
adapted from End of Life diabetes Care: Clinical care recommendations 2nd edition

Last Days of Life Diabetes Care Management



Key

^
- Byette (Exenatide)
- Victoza (Liraglutide)
- Lyxumia (Lixisenatide)

#
- Humulin I
- Insulatard
- Insuman basal

+
- Novorapid
- Humalog
- Apidra

*
Based on 25% less than total previous daily insulin dose

- Keep tests to a minimum. It may be necessary to perform some tests to ensure unpleasant symptoms do not occur due to low or high blood glucose.
- It is difficult to identify symptoms due to “hypo” or hyperglycaemia in a dying patient.
- If symptoms are observed it could be due to abnormal blood glucose levels.
- Test urine or blood for glucose if the patient is symptomatic
- Observe for symptoms in previously insulin treated patient where insulin has been discontinued.

For queries relating to the diabetes flowchart please contact the Diabetes Specialist Nurses in York: 01904 726510 and in Scarborough: 01723 342274
For queries relating to palliative care please contact the Palliative Care Team

General principles of mouth care

Assess the whole mouth daily.

Clean the teeth and tongue using a toothbrush and toothpaste, morning and night.

Ensure all toothpaste is rinsed away.

Offer mouth care every 3 to 4 hours using a soft toothbrush.

Use lip salve for dry lips. Care when using oxygen mask.

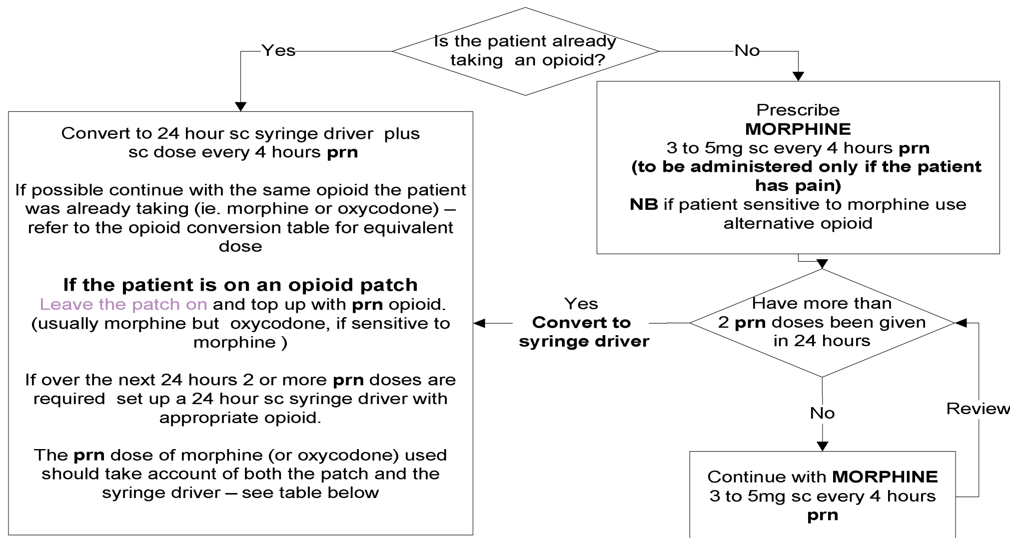
Note any history of pain, dry mouth, change of taste, medications and respond if required.

Document findings

Problem	Action
Dry mouth	Consider discontinuing contributing factors, e.g. medication. If required, consider humidifying oxygen. Implement general mouth care principles. Offer fluids hourly if appropriate. Consider topical saliva substitutes, e.g. Saliva Orthana spray or Oral Balance gel/ spray.
Coated tongue	Implement general mouth care principles. Rinse the mouth after food with water. Encourage fluids as appropriate. If no improvement in 24 hours consider infection as a cause.
Pain / mucositis / ulceration	Implement general mouth care principles. Consider **analgesia** – topical/systemic. Use soft toothbrush for hygiene. Consider diluting mouthwash if the patient finds their use painful. **Seek specialist advice if symptoms continue.**
Infection	Rinse mouth 3 times per day with chlorhexidine 0.2% (Corsodyl) or sodium chloride 0.9%. Implement general mouth care principles. Check for thrush and treat with antifungal, if appropriate. e.g. fluconazole or nystatin

Pain Control

(Non renal pathway – see next page for patients with renal failure)



Remember :
Any change in the syringe driver dose should take account of the number of **sc prn doses** given over the last 24 hours. If you change the syringe driver dose remember to also change the 4 hourly **prn** dose

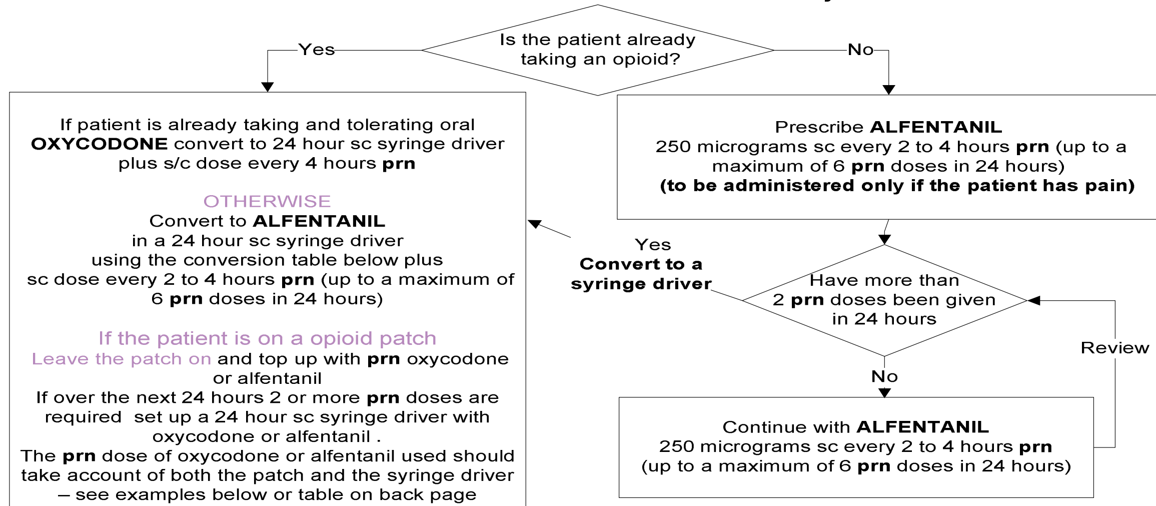
To calculate the prn dose of morphine
Prescribe 1/6th of the 24 hour dose in the driver
e.g 20mg sc via driver over 24 hours will require 3 to 5mg every 4 hours **prn**

Strong opioid	Conversion to s/c morphine over 24 hours	Example
Zomorph/ MST	Divide total oral morphine dose by 2	Zomorph 30mg bd = 30mg Morphine sc in 24 hours
Fentanyl patch	**Standard practice is to leave fentanyl patch on patient** and continue to change every 3 days. Top up with sc doses of morphine and review. **To calculate prn sc morphine dose to supplement patch** a) Work out equivalent 24 hour oral morphine dose for a given patch b) Divide by 2 to get sc 24 hour morphine dose c) Divide by 6 to get sc morphine **prn** dose The **prn** dose can be given every 3 to 4 hours up to a maximum of 6 **prn** doses in 24 hours. A syringe driver may be required if 2 or more **prn** doses are used. Subsequent breakthrough dose should be calculated from the dose of morphine in the syringe driver and the equivalent given by patch.	Fentanyl patch 75 microgram changed every 72 hours is approximately equivalent to morphine 270mg oral or 140mg sc over 24 hours. **Leave patch on** and calculate initial **prn** sc morphine dose as **1/6th** of 140mg morphine sc over 24 hours = 25mg morphine sc. A syringe driver may be required if 2 or more doses used in the past 24 hours. E.g. If 2 **prn** doses are used (2 x 25mg) the syringe driver would be set up with 50mg morphine sc over 24 hours. **Calculate subsequent prn morphine s/c doses** • Add morphine syringe driver dose i.e. 50mg sc with equivalence in patch i.e. 140mg morphine sc. Total equivalent sc morphine dose in 24 hour = 50mg + 140mg =190mg. • New **prn** doses would be 1/6th of 190mg = 32mg (prescribe 30mg for convenience).

It is good practice to document calculations in notes and check dose conversions with a colleague. Consult colourful opioid conversion chart. If unsure please contact the palliative care team for advice
Remember to include prn doses in your calculations

Pain control in renal failure

(Patients with severe renal failure i.e. GFR < 30mL/min use oxycodone or alfentanil)



Remember :
Any change in the syringe driver (SD) dose should take account of the number of **sc prn doses** given over the last 24 hours. If you change the SD dose remember to also change the **prn** dose

To calculate the prn dose of oxycodone or alfentanil
For **prn** dose prescribe 1/6th of the 24 hour syringe driver dose
e.g 3mg alfentanil sc via driver over 24 hours will require 500 microgram alfentanil sc **prn** every 2 to 4 hours **prn** (up to a maximum of 6 **prn** dose in 24 hours)
E.g. 20mg oxycodone sc via driver over 24 hours will require 3mg oxycodone sc **prn** every 3 to 4 hours
(If the patient is also on a patch you must calculate how much alfentanil or oxycodone this is equivalent to and include this in the 24 hour dose which you use as a basis for your **prn** dose)

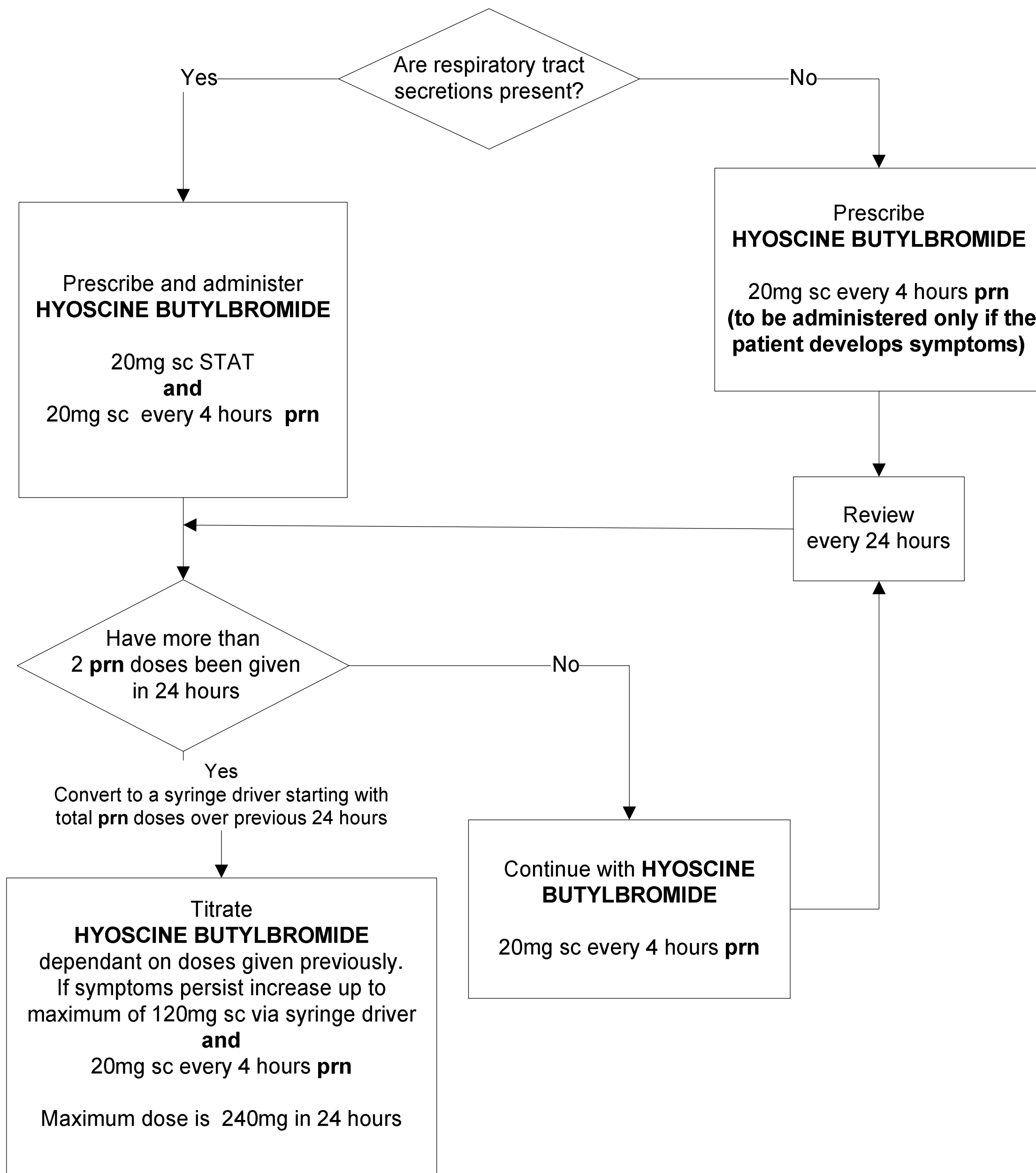
Strong opioid	Conversion to sc alfentanil over 24 hours	Conversion to sc oxycodone over 24 hours
MST/ Zomorph	Divide total daily oral morphine dose by 30 Zomorph 30mg bd= 2mg alfentanil sc over 24 hours	Divide total daily oral morphine by 4 Zomorph 30mg bd = 15mg Oxycodone sc 24 hours
OxyCodone	Divide total oral oxycodone by 15 OxyContin15mg bd =2mg alfentanil sc over 24 hours	Divide total oral oxycodone by 2 OxyContin15mg bd =15mg oxycodone sc over 24 hours
Fentanyl patch microgram/hour	**Standard practice is to leave fentanyl patch on patient** and continue to change every 3 days. Top up with sc **prn** alfentanil and review. **To calculate initial prn sc alfentanil dose to supplement patch** • **1/6th** of equivalent 24 hour alfentanil sc dose e.g. Fentanyl 75 micrograms is approximately equivalent to 9mg alfentanil sc over 24 hours. • 1/6th of equiv 24 hour alfentanil sc dose is 9mg divide by 6 = **1.5mg** • The **prn** dose can be given every 2 to 4 hours up to a maximum of 6 **prn** doses in 24 hours. • A syringe driver may be required if 2 or more **prn** doses are used. E.g. If 2 **prn** doses are used (2 x 1.5mg) the syringe driver would be set up with 3mg alfentanil over 24 hours. **Calculate subsequent prn alfentanil sc doses** • Add alfentanil syringe driver dose i.e. 3mg sc with equivalence of alfentanil in patches i.e. 9mg sc. Total equivalent 24 hour sc alfentanil dose = 3mg + 9mg =12mg. • New **prn** dose would be 1/6th of 12 mg = 2mg **Prn** doses will need increasing as syringe driver requirements increase.	**Standard practice is to leave fentanyl patch on patient** and change to change every 3 days. Top up with sc **prn** oxycodone and review. **To calculate initial prn sc oxycodone dose to supplement patch** • **1/6th** of equivalent 24 hour oxycodone sc dose e.g. Fentanyl 75 micrograms is approximately equivalent to 70mg oxycodone sc over 24 hours. • 1/6th of equiv 24 hour oxycodone sc dose is 70mg divide by 6 = **10mg** • The **prn** dose can be given every 2 to 4 hours • A syringe driver may be required if 2 or more **prn** doses are used. E.g. If 2 **prn** doses are used (2 x 10mg) the syringe driver would be set up with 20mg oxycodone over 24 hours. **Calculate subsequent prn oxycodone sc doses** • Add oxycodone syringe driver dose i.e. 20mg sc with equivalence of oxycodone in patches i.e. 70mg sc. Total equivalent 24 hour sc alfentanil dose = 20mg + 70mg =90mg. • New **prn** dose would be 1/6th of 90 mg = 15mg **Prn** doses will need increasing as syringe driver requirements increase.

It is good practice to document calculations in notes and check dose conversions with a colleague. Consult colourful opioid conversion chart. If unsure please contact the palliative care team for advice

Remember to include prn doses in your calculations

Respiratory tract secretions

(Remember you cannot clear existing secretions, but you can help stop further production)



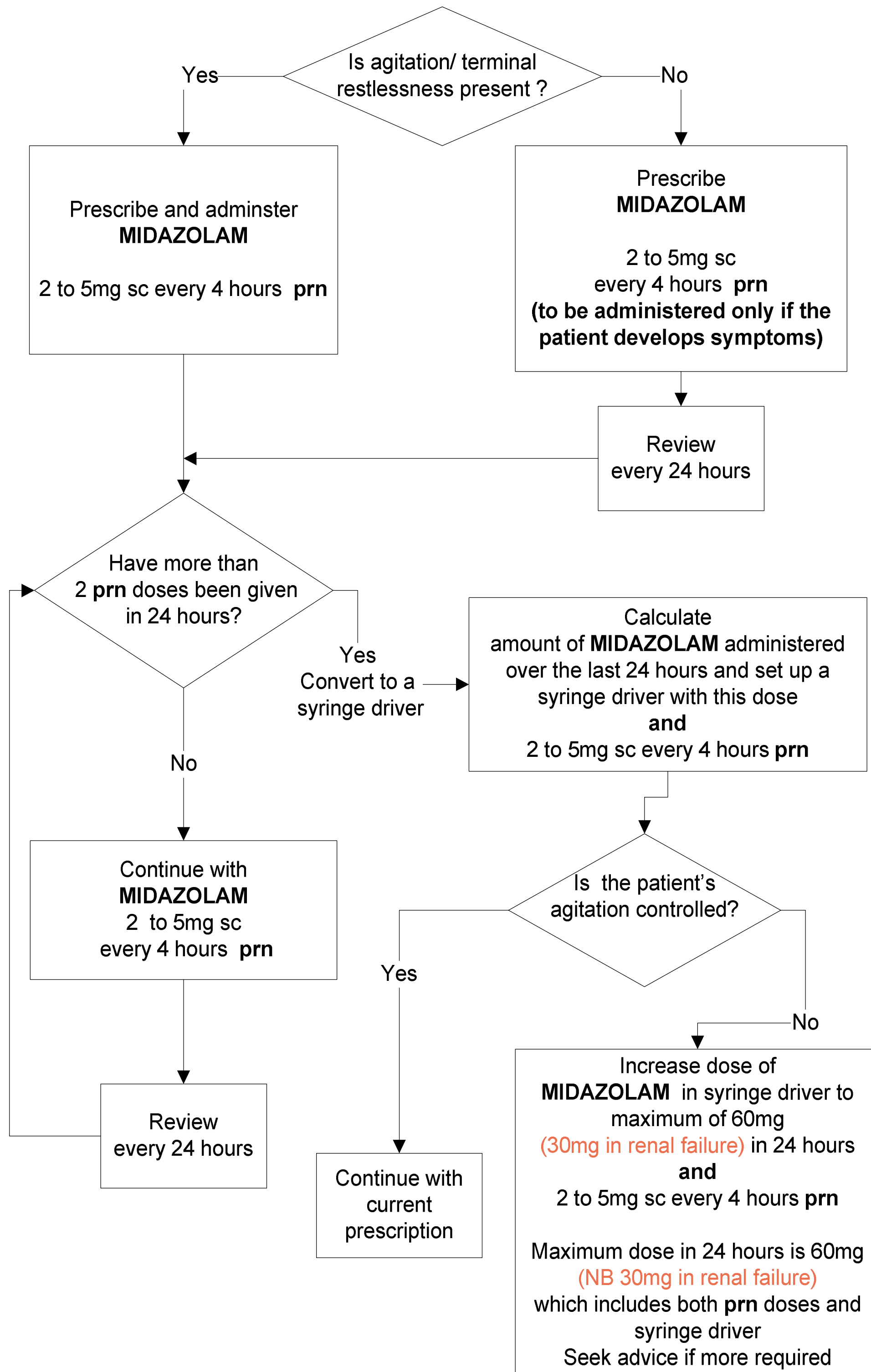
HYOSCINE BUTYLBROMIDE (BUSCOPAN) above 60mg in 24 hours may precipitate when mixed with CYCLIZINE. If problems discontinue cyclizine and switch to levomepromazine.

GLYCOPYRRONIUM may be used as an alternative if hyoscine butylbromide not effective (reduced doses in renal failure).

HYOSCINE HYDROBROMIDE is **not recommended in patients with renal failure** because of excessive drowsiness or paradoxical agitation.

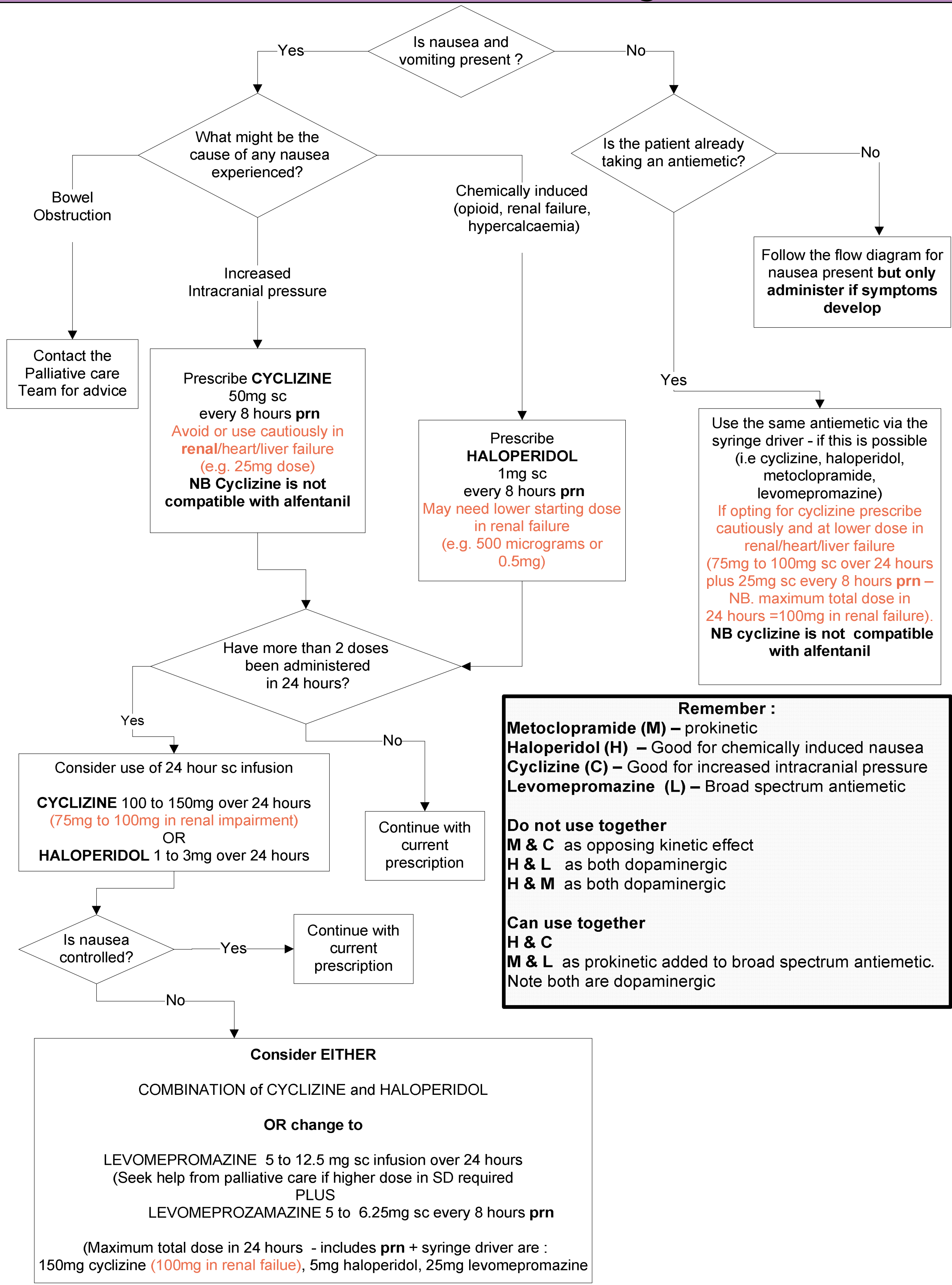
Agitation / Terminal restlessness

Before prescribing have all reversible causes been excluded? e.g. urinary retention



NB if **uncontrolled** on a maximum of 60mg midazolam (30mg in renal failure) **consider levomepromazine** starting at 6.25mg **prn**. Further doses may need to be added to the syringe driver. If symptoms continue contact the Specialist Palliative Care Team.

Nausea and Vomiting

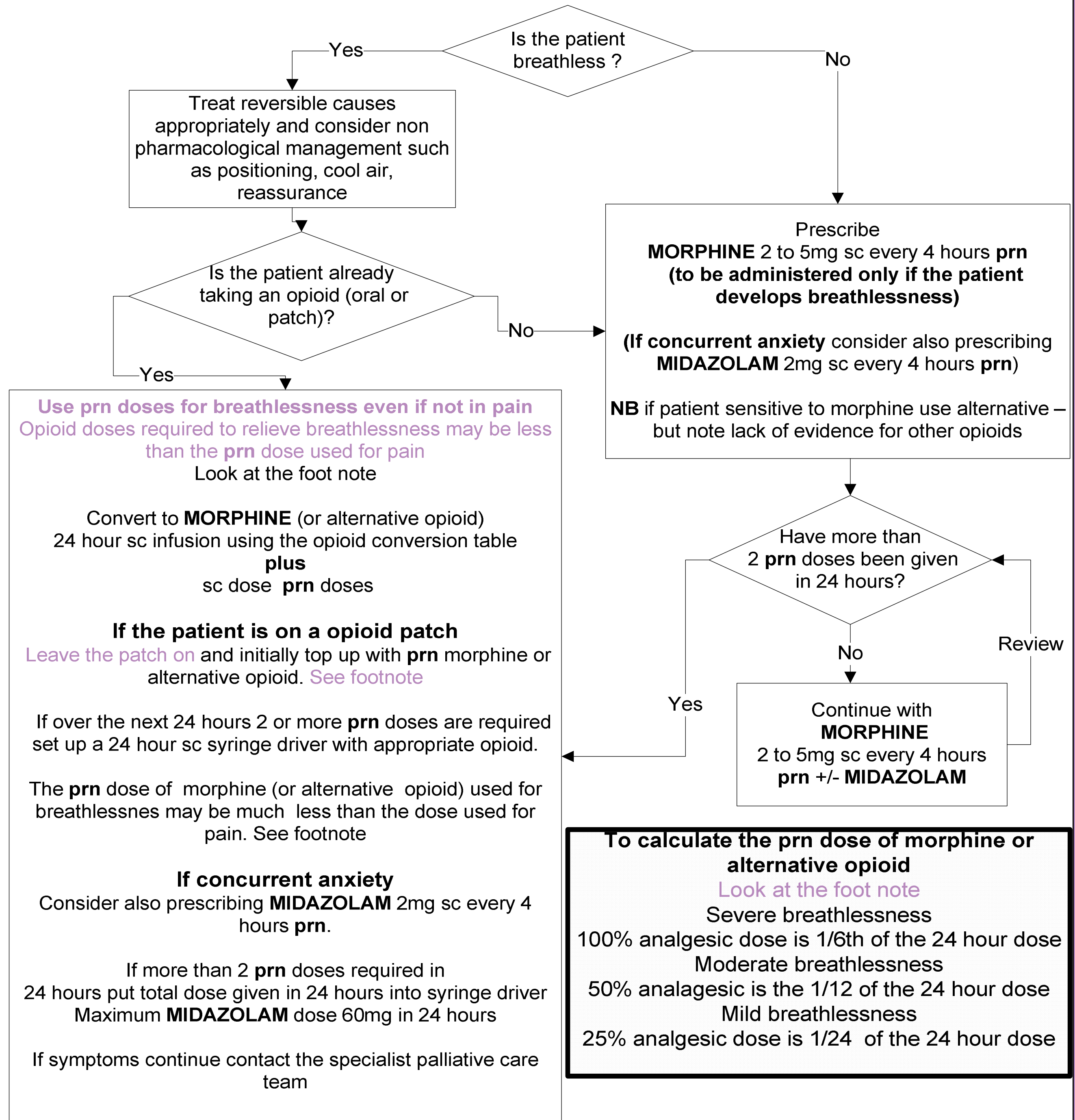


Dyspnoea (Breathlessness)

(Non renal pathway –see next page for patients with renal failure)

Opioids are more useful for patients who are breathless at rest than those who are breathless on exertion

Reference page 368 of PCF4.



Note :

Severe breathlessness >7/10 a dose that is 100% of 4 hourly analgesic dose may be needed

Moderate breathlessness 4 to 6/10 a dose that is 50 to 100% of 4 hourly analgesic dose may be needed

Mild breathlessness < 3/10 a dose that is 25 to 50% of 4 hourly analgesic dose may be needed

Morphine is normally used for breathlessness. This is the opioid which has the best evidence base for treatment of breathlessness. In renal impairment however morphine accumulates and alfentanil or oxycodone is preferred for this reason.

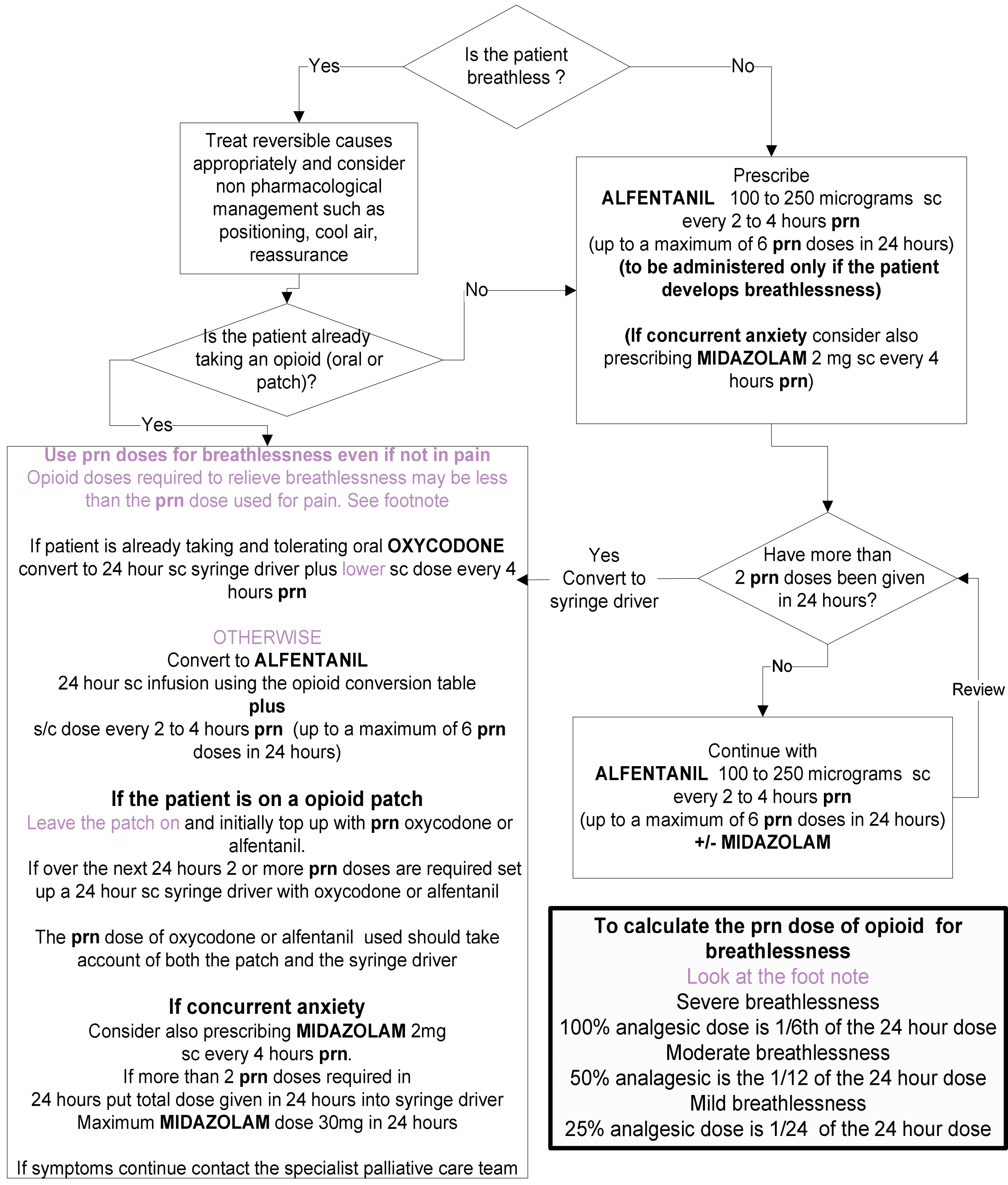
Dyspnoea (Breathlessness)

Dyspnoea (Breathlessness) in Renal Failure

(Patients with severe renal failure i.e. GFR < 30mL/min)

Opioids are more useful for patients who are breathless at rest than those who are breathless on exertion

Reference page 368 of PCF4.



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