NHS
Worcestershire Acute Hospitals NHS Trust

Hospital Palliative Care Team

INDIVIDUALISED LAST DAYS OF LIFE CARE PLAN(WR5313) GUIDANCE ON USE AND IMPLEMENATION

Version 1.5 22nd November 2018

Guidance on use of the document for Worcestershire Acute Hospital Trust

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Worcestershire Acute Hospital NHS Trust Individualised Last Days of Life Care Plan for Adults (WR5313)

Background

The 'Individualised Last Days of Life Care Plan for Adults' (WR5313) is the care plan for the care of adult inpatients who are in the last days of life in Worcestershire Acute Hospitals. The care plan has been developed to replace the previous care plan 'Optimising Care as Life Ends' (WR4668) from 3rd December 2018. The new plan has been developed following recognition that 'Optimising Care as Life Ends' was not being fully utilised across the Trust and in order to reflect recent national end of life care strategies. The work was also undertaken as part of a national programme 'Building on the Best' that was designed to improve end of life care in hospitals. The new plan has been designed to:

- Be explicitly based on the 'Five priorities of care for the dying person' and NICE Guidance Care of dying adults in the last days of life. *(Leadership Alliance for the Care of Dying People. One Chance to Get it Right. June 2014 , NICE NG31. Care of dying adults in the last days of life. December 2015);*
- Reflect feedback from healthcare professionals in Worcestershire Acute Hospital Trust on their previous experience with care plans;
- Contain helpful reference information such as opioid prescribing at the end of life that health care professionals at Worcestershire Acute Hospitals had identified as helpful;
- Include 'stickers' which can be added to the medical notes on a daily basis to aid daily review;
- Include a symptom observation chart to improve symptom control assessment;
- Be a more succinct, user-friendly, document.

Individualised Last Days of Life Care Plan for Adults Components

The Individualised Last Days of Life Care Plan for Adults consists of the following components:

- Page 1 & 2 – Assessment of the dying person based on the 'Five Priorities of Care for the Dying Person';
- Page 3 - Algorithm for prescribing opioid analgesia at the end of life;
- Page 4 – Guidance on Anticipatory Medication prescribing (incorporating new guidance for patients with renal impairment) and basic pharmacological considerations at the end of life chart that outlines syringe driver drug compatibility;
- Page 5 – Palliative Care Symptom Observation Chart (NEWS style observation chart to assess symptoms);
- Page 6 – Guidance on the use of Palliative Care Symptom Observation chart and outline of Abbey Pain scale tool;
- Four 'Daily Review' care stickers to be added in the medical notes as prompts to ensure that the 'Five priorities of care for the dying person' are being considered on a daily basis.

Guidance on the use of the Individualised Last Days of Life Care Plan for Adults.

General Notes

- The document is designed for use at both sites of Worcestershire Acute Hospital NHS Trust (Worcestershire Royal Hospital and Alexandra Hospital, Redditch).
- The plan is designed for use in adults only.
- Patient identifiers (either labels or handwritten) should be applied to all relevant pages of the document when being used for patient care.
- The form should be filed in the notes contemporaneously.
- The care plan should be reviewed every 24 hours. On day one of use of the care plan this would be the first two pages of the 'Individualised Last Days of Life Care Plan for Adults' with the stickers in the medical notes used in subsequent 24 hour time periods.
- Patients, and/or those important to them, should be offered a copy of the care plan (that is pages 1 and 2). However, it is recognised that there may be circumstances where it may not be appropriate to offer a copy of the care plan to all patients and/or those important to them.

Recognise

The possibility [that a person may die within the next few days or hours] is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.

In any advanced incurable illness, a point will arrive where death becomes an inevitable and natural process. Typically, at such times, cumulative pathology exceeds what available therapies can address. **In the context of a patient with a progressive, non-curable irreversibly deteriorating illness** cues that they may be approaching the last days of life include:

- Profound weakness and increasing amounts of time spent asleep or variable consciousness;
- Withdrawal from the world and deteriorating cognition;
- Reduced food and fluid intake, and progressive difficulty in swallowing medication resulting in an inability to maintain adequate hydration and nutrition;
- Increasing care needs.

For patients who do not meet this criteria and who may have a reversible component to their condition the Individualised Last days of Life Care Plan for Adults should <u>not</u> be commenced and the AMBER Care Bundle considered.

The Individualised Last Days of Life Care Plan for Adults should be commenced for every patient who is in the last days of life when this has been agreed by the multidisciplinary team who have responsibility for that patient's care. The document should be completed by the team with clinical responsibility for the patient (that is, the ward team). Information should be entered about the patient's diagnosis and past medical history and why the patient is being recognised as being at the end of life, including if any reversible causes have been considered. If detailed conversations have already taken place about recognition of the end of life and these have already been clearly documented, the entry does not need to be repeated but the location in the medical notes should be indicated here (for example, 'See entry by Dr Jones on 4th July at 3.30pm'). However, if a copy of the care plan is being given to patients, and/or those important to them, it is necessary that this section is completed in full.

This document is for use when the multidisciplinary team consider the patient to be irreversibly dying and in the last days of life. For patients not meeting these criteria please consider use of Amber Care Bundle.
Diagnosis & Relevant Past Medical History:
Recognise
Please indicate reasons for identifying the patient as approaching their last days of life, including if any reversible causes have been considered. Or, indicate below where the relevant entry can be found in the medical notes.

Communicate

Sensitive communication takes place between staff and the dying person, and those identified as important to them.

Sensitive, open and honest communication between staff and the person who is dying, and those identified as important to them, including carers, is critically important to good care. Clear, understandable and plain language must be used verbally and in all other forms of communication as healthcare professionals discuss prognosis and goals of care, even in the dying phase. Communication interactions should occur regularly and understanding checked.

Relevant conversations and their associated documentation should be summarised in the Individualised End of Life Care Plan for Adults. If relevant end of life conversations with patients, and/or those important to them, have already taken place prior and been documented prior to the commencement of the plan the location of these entries in the medical notes should be highlighted.

Communicate
Document the conversations you have had with the patient and/or those important to them (specifying their relationship to the patient) around prognosis & goals of care. (Continue in medical notes if necessary) Or, indicate below where the relevant entry can be found in the medical notes.
Has a DNACPR decision been made and documented (in keeping with Trust policy)? _____ Yes / No

In this section it should be documented if a DNACPR decision has been made and documented. DNACPR (do not attempt cardiopulmonary resuscitation) decisions should be made in keeping with Trust Policy.

Involve

The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.

Individuals vary in the extent to which they wish to be involved in decisions about their own treatment, though most would want to make or influence decisions about the care they receive, and the way this is delivered. Individuals also vary in the extent to which they wish their families, and/or those important to them, to be involved in decision-making. Sensitive communication is needed to ascertain the wishes of the dying person and their wishes must be respected.

Where it is established that the dying person lacks capacity to make a particular decision, the decision made or action taken on their behalf must be in their best interests, and they should still be involved as far as possible in that decision, in keeping with the Mental Capacity Act Legislation.

Involve
Has the patient expressed a preferred place of care? Yes / No (If no, please explore with patient/relative)
Patient's preferred place of care _____
Does the patient have any advance care planning in place or expressed preferences around the following:
• Advance Care Plan _____ Yes / No
• Valid Advanced Decision to Refuse Treatment (ADRT) _____ Yes / No (If Yes, please ensure copy is in notes)
• Lasting Power of Attorney for health and well-being _____ Yes / No (If Yes, please ensure copy is in notes)
• Preference for organ or tissue donation _____ Yes / No Details_____
• Deactivation of Implantable Cardioverter Defibrillator (ICD) _____ Yes / No / NA : Date ICD deactivated _____

The Individualised Last Days of Life Care Plan for Adults specifically asks teams to consider the following:

- **Patient's preferred place of care**
- **Advance care plans** – statements made by patients about their general care preferences (such as: where they may want to be cared for; who is important to them; etc.)
- **Advance Decision to Refuse Treatment** – if valid, these are legally binding (if the circumstances in the ADRT are met) refusals for treatment. [For further information see WAHT-CG-490 Policy for Advance Decisions (Living Wills)]
- **Lasting Power of Attorney *for Health and Wellbeing*** - a person formally nominated (with appropriate documentation) to make medical decisions on behalf of patients who lack capacity.
- **Preference for organ and tissue donation** – Many patients, even with malignancy, are able to donate some form of tissue. For further information see NHS Blood and Transplant Service webpage.
- **Deactivation of Implantable Cardioverter Defibrillator (ICD) –** this will require discussion with the cardiology team.

Support

The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.

Families and those important to the dying person, including carers, have their own needs which they, and others, can overlook at this time of distress. The Individualised Last Days of Life Care Plan for Adults specifically asks teams to consider if the patient, or those important to them, has any spiritual, cultural or psychological needs. Although it is not always possible to meet the needs or wishes, listening and acknowledging these can help. It is not anticipated that the healthcare team would be able to address issues themselves but upon identifying issues appropriate support and advice can be sought (for example, from chaplaincy service.)

It is important for health care professionals to consider that some of these issues may be relevant and important to the care of the patient after death (for example, faith-related death rites or where burial within 24 hours of death).

A way of approaching this would be to ask **"Is there anything from a cultural or religious perspective that it is important that we are aware of at this time?"**

Support
Does the patient, or those important to them, have any spiritual, cultural or psychological needs?_____ Yes / No Please outline what they are and how these are being addressed Please be aware that these issues may be important for care of the patient after death.

Plan and Do

An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

The 'Individualised Last Days of Life Care Plan for Adults' requires healthcare teams to consider, on an individual basis, the ongoing treatment plan for the dying patient.

1. **Review investigations, interventions and treatments** – including blood tests, IV antibiotics, medication reviews, cannula plan, diabetes monitoring and potential for seizures.

Plan and Do
Review investigations, interventions and treatments
Have routine observations (NEWS chart) been discontinued? Yes / No **Observations should only be continued if actions will be taken on them** Ensure that reviews have taken place on the need for any further: • Blood test discontinued _____ Yes / No / Other _____ • IV antibiotics discontinued _____ Yes / No / Other _____ • Current medication review and discontinue unnecessary medications _____Yes / No
IV Cannula plan: Please indicate if appropriate to remove current cannula, if present, and circumstances when it would be appropriate to re-cannulate.
Diabetes monitoring and management plan: (please contact either Diabetes Specialist Nurses or Palliative Care Team if advice needed)
Is this patient at risk of seizures?_____ Yes / No If yes, please indicate management plan

   - With regards to IV cannula, this applies to any IV access route – including venflons and PICC lines. It may be appropriate to utilise these routes even in the last days and hours of life in some circumstances where the benefits of continuing to utilise these routes are greater than the burdens of other routes.
   - For patients with diabetes (irrespective of whether Type 1, Type 2 or steroid induced) their care plan should include a plan for monitoring and management. If health care teams are uncertain of this aspect of the care plan advice can be sought from either the Diabetes Specialist Nurses or the Palliative Care Team.
   - Patients who may be at risk of seizures, includes but is not limited to: patients with a history of epilepsy; patients with brain metastasis; patients with recent seizures of unknown aetiology. For these patients a seizure management plan may be required and background anti-seizure medication may need to be continued even in the last days and hours of life. Plans should consider if background seizure control is needed and/or if an acute seizure treatment plan is also needed. If healthcare professionals are uncertain as to how to address this issue specialist advice can be sought from the Palliative Care Team.

2. **Symptom control** -This section prompts the health care team to commence use of palliative care symptom observation chart that should be added to the bedside notes. Also, within this section baseline assessment of symptoms and plan for their management (at the time of commencement of the care plan) should occur.

Control of symptoms	
1. Palliative Care Symptom Observation Chart must be commenced and added to the nursing notes (copy at the back of this document) 2. Use an individualised approach to anticipatory prescribing based on the symptoms likely to occur in each case, considering route and dose. Ensure that anticipatory medications are reviewed as the patient's needs change.	
Symptom Assessment (Baseline Assessment)	**Action (i.e.: prescriptions, care given)**
Pain	
Nausea and / or Vomiting	
Restlessness	
Respiratory Secretions	
Mouth Care	

The baseline assessment of symptoms should take place and outlines of actions taken or required made alongside the relevant symptom. An example of how this section may be completed is given below:

Symptom Assessment (Baseline Assessment)	**Action (i.e.: prescriptions, care given)**
Pain Severe abdominal pain (not colicky)	Stat PRN analgesic to be given. Background PO opioid to be converted to CSCI
Nausea and / or Vomiting Controlled with regular anti-emetic	PO Cyclizine converted to SC in CSCI. Alternative anti-emetic (Levomepromazine) PRN prescribed
Restlessness Nil present	PRN SC prescribing to be considered if develops
Respiratory Secretions Nil present	PRN SC Hysocine Butylbromide available if develops
Mouth Care Severe dry mouth	Mouth care performed, nursing team will review regularly

3. **Nutrition and Hydration** –In this section an outline of the plan for nutrition and hydration is outlined. It is recognised that this can be a complex issue and burden and benefits of the use of artificial hydration (including subcutaneous fluids) and nutrition should be considered. Any decisions and discussions that have taken place regarding this topic prior to the commencement of the 'Individualised Last Days of Life Care Plan for Adults' should also be highlighted in this section.

Nutrition and Hydration
All patients who are able to take sips of fluids should be offered drinks regularly. If a patient's swallowing is impaired, they may still choose to take sips or 'feed at risk' and this should be assessed on an individual basis to maximise overall comfort. Consider the possible benefits or burdens of artificial hydration and nutrition. Document any decisions and discussions below:

Signatures and Agreements

In this section of the document there should be:

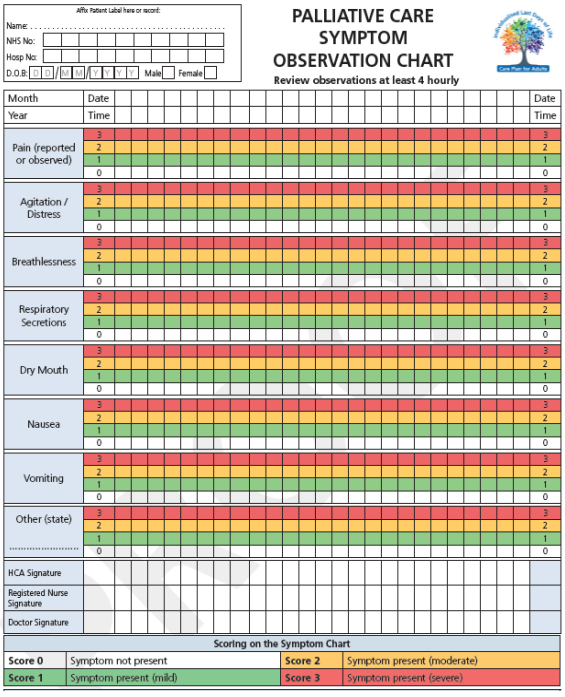
1. Consideration of whether the patient requires Hospital Palliative Care Team input;
2. Details of the members of the multidisciplinary team commencing the Individualised Last Days of Life Care Plan including both medical and nursing team signatures;

3. Counter-signature by the consultant in charge of the patient's care which is to be undertaken at the earliest practical opportunity;
4. Indication that if a copy of the care plan (that is, pages one and two) have been offered to the patient and or those important to them and accepted the name of the individual who has received the copy. It is acknowledged that it will not be appropriate in all cases to offer a copy of the care plan.

Does the Hospital Palliative Care Team need to be involved? ... Yes / No (See Posters/Palliative Care Intranet Page for referral criteria). If yes, please ensure patient and/or those important to them are aware of referral. Refer on ext. 42085.	
Name of Doctor completing form _____ Grade _____ Signature _____ GMC Number _____ Date _____ Name of Nurse Responsible for patient on day document completed _____ Nurse Signature _____ Date _____ Name of other members of the multidisciplinary team involved in the decision to use individualised last days of life care plan document:	**Consultant in charge of patient's care to counter-sign.** Date: Name: Signature: GMC number:
Copy offered to patient and / or those important to them? _____ Yes / No Name of person copy given to _____	

Palliative Care Symptom Observation Chart

This chart is designed to replace the NEWS chart for patients on the Individualised Last Days of Life Care Plans for Adults and designed to assist health care professionals in assessing and managing physical symptoms in dying patients. For patients with dementia, delirium or who cannot verbalise the Abbey Pain Scale tool is advised to help assess pain. A copy of the Abbey Pain Scale is available on the reverse of the Palliative Care Symptom Observation chart.

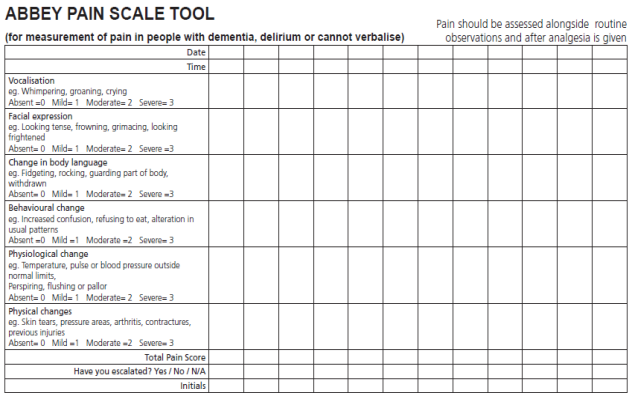


Affix Patient Label here or record:
Name:
NHS No:
Hosp No:
D.O.B: D D / M M / Y Y Y Y Male Female

PALLIATIVE CARE SYMPTOM OBSERVATION CHART
Review observations at least 4 hourly

Month / Year	Date / Time																								Date / Time
Pain (reported or observed)	3																								3
	2																								2
	1																								1
	0																								0
Agitation / Distress	3																								3
	2																								2
	1																								1
	0																								0
Breathlessness	3																								3
	2																								2
	1																								1
	0																								0
Respiratory Secretions	3																								3
	2																								2
	1																								1
	0																								0
Dry Mouth	3																								3
	2																								2
	1																								1
	0																								0
Nausea	3																								3
	2																								2
	1																								1
	0																								0
Vomiting	3																								3
	2																								2
	1																								1
	0																								0
Other (state)	3																								3
	2																								2
	1																								1
	0																								0
HCA Signature																									
Registered Nurse Signature																									
Doctor Signature																									

Scoring on the Symptom Chart			
Score 0	Symptom not present	**Score 2**	Symptom present (moderate)
Score 1	Symptom present (mild)	**Score 3**	Symptom present (severe)



ABBEY PAIN SCALE TOOL
(for measurement of pain in people with dementia, delirium or cannot verbalise)

Pain should be assessed alongside routine observations and after analgesia is given

Date												
Time												
Vocalisation eg. Whimpering, groaning, crying Absent =0 Mild= 1 Moderate= 2 Severe= 3												
Facial expression eg. Looking tense, frowning, grimacing, looking frightened Absent= 0 Mild= 1 Moderate= 2 Severe =3												
Change in body language eg. Fidgeting, rocking, guarding part of body, withdrawn Absent= 0 Mild= 1 Moderate= 2 Severe =3												
Behavioural change eg. Increased confusion, refusing to eat, alteration in usual patterns Absent =0 Mild =1 Moderate =2 Severe= 3												
Physiological change eg. Temperature, pulse or blood pressure outside normal limits, Perspiring, flushing or pallor Absent= 0 Mild= 1 Moderate= 2 Severe= 3												
Physical changes eg. Skin tears, pressure areas, arthritis, contractures, previous injuries Absent= 0 Mild =1 Moderate =2 Severe= 3												
Total Pain Score												
Have you escalated? Yes / No / N/A												
Initials												

Guidance on use of the symptom observation chart

- All sections must be completed accurately and initialled.
- The minimum frequency of observation is four hourly.
- If Health Care Assistants are completing observations they should be countersigned by a registered nurse within 30 minutes.

- All symptoms are scored on 0-3 (0 representing symptom not present, 1,2,3 representing mild, moderating and severe respectively.)
- Actions taken on the symptoms scores are outlined on the chart and will be discussed in more details below.

Actions to be taken on symptom score	
Symptom absent	Care plan continues
Symptom present, resolves spontaneously	Care plan continues, consider if adaptations may be required
Symptom present, requires intervention* to improve (*Intervention may be non-pharmacological, such as repositioning patient, or pharmacological with PRN medications)	Care plan continues. If 3 consecutive symptom scores of 2 are present (for any symptom) review of the care plan required – this may be discussion with a more senior member of your team, discussion with palliative care team.
Symptom present, does not improve following intervention	Consider: use of second line interventions for symptom management; discussion with a more senior member of your team; discussion with the palliative care team.

Actions to be taken on Symptoms Scores

- **Symptom absent** – the care plan would continue unchanged

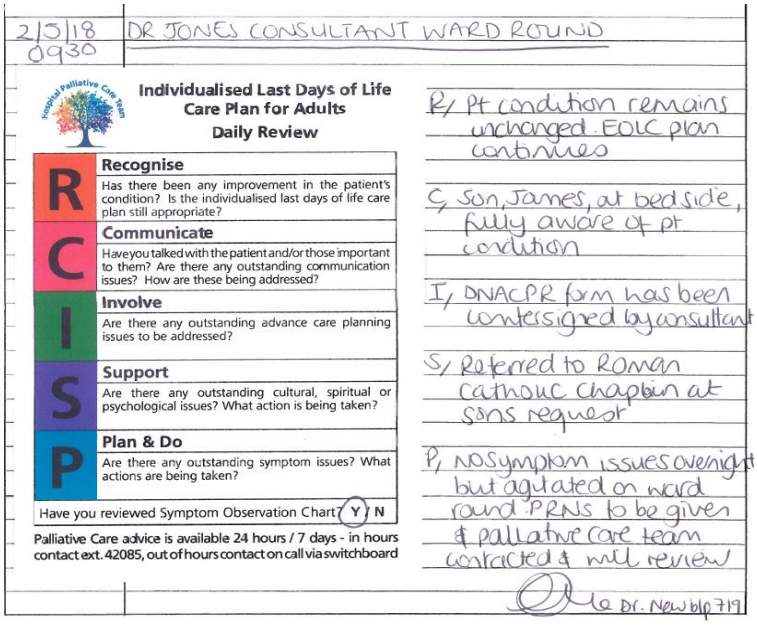
- **Symptom present, resolves spontaneously** - by spontaneously it is meant that the symptom resolves within a few minutes without intervention. In this circumstance the care plan continues and adaptions should be considered. For example, a patient with pain triggered by movement the pain may settled spontaneously when resting but the team should consider if a plan for pre-movement analgesia should be made.

- **Symptoms present, requires intervention to improve** – If the symptom is present at any level – that is, mild, moderate or severe, and dose not resolve spontaneously intervention will be required. Intervention may be non-pharmacological such as repositioning the patient who is short of breath or may be pharmacological with the use of one of the as required medications. If an intervention is undertaken the symptoms should be re-scored 30 minutes after the intervention. If there are three consecutive symptom scores of two or more for any symptom, this should prompt review of the care plan from either a more senior member of the team with clinical responsibility or discussion with the palliative care team.

- **Symptom present, does not improve following intervention** – If the symptom does not improve following initial intervention, the clinical team should consider use of a second line intervention (which may be an alternative prescription) and discussion with a more senior member of the team or discussion with the palliative care team.

Ongoing Daily Review for patients commenced on Individualised Last Days of Life Care Plan for Adults

Patients commenced on Individualised Last Days of Life Care Plans for Adults should have the care plans reviewed at least every 24 hours. The review should be undertaken by the multidisciplinary care team with responsibility for the patient. The stickers are designed to be used on the days subsequent to the initiation of the care plan. The stickers should be removed from the sheet and added to the medical notes with relevant annotation made alongside. The sticker also prompts the team to review the symptom observation chart. An example of how the stickers should be used is given below:



2/5/18 0930 DR JONES CONSULTANT WARD ROUND

Individualised Last Days of Life Care Plan for Adults
Daily Review

R – Recognise
Has there been any improvement in the patient's condition? Is the individualised last days of life care plan still appropriate?

C – Communicate
Have you talked with the patient and/or those important to them? Are there any outstanding communication issues? How are these being addressed?

I – Involve
Are there any outstanding advance care planning issues to be addressed?

S – Support
Are there any outstanding cultural, spiritual or psychological issues? What action is being taken?

P – Plan & Do
Are there any outstanding symptom issues? What actions are being taken?

Have you reviewed Symptom Observation Chart? (Y) N

Palliative Care advice is available 24 hours / 7 days - in hours contact ext. 42085, out of hours contact on call via switchboard

R/ Pt condition remains unchanged. EOLC plan continues

C/ Son, James, at bedside, fully aware of pt condition

I/ DNACPR form has been countersigned by consultant

S/ Referred to Roman Catholic chaplain at sons request

P/ NO symptom issues overnight but agitated on ward round. PRNs to be given & palliative care team contacted & will review

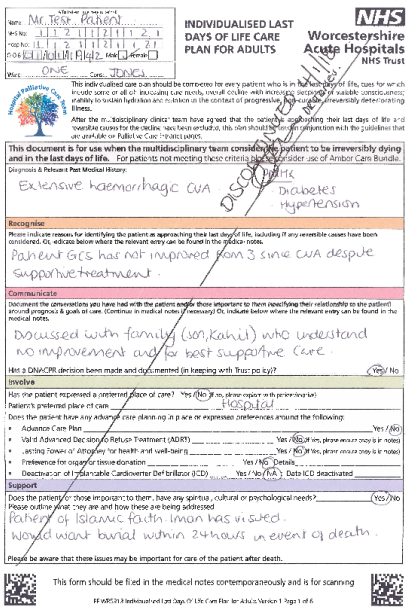
Dr. New bleep 719

Discontinuation of the Individualised Last Days of Life Care Plan for Adults

If the patient's **condition unexpectedly improves** and the care plan is no longer appropriate the following actions should be taken:

- Document the reasons why the care plan is no longer appropriate in the medical notes;
- Discuss (and document) the change in the direction of care, and the reasons for this, with the patient and/or those important to them;
- Discontinue use of the 'Individualised Last Days of Life Care Plan for Adults';
- Cross through the document and sign and date. The document should be retained in the patient's notes. The cross through should occur in a manner that allows the document to remain legible but clear that the document should be discontinued.

For example:



INDIVIDUALISED LAST DAYS OF LIFE CARE PLAN FOR ADULTS

NHS Worcestershire Acute Hospitals NHS Trust

Extensive haemorrhagic CVA

Diabetes

Hypertension

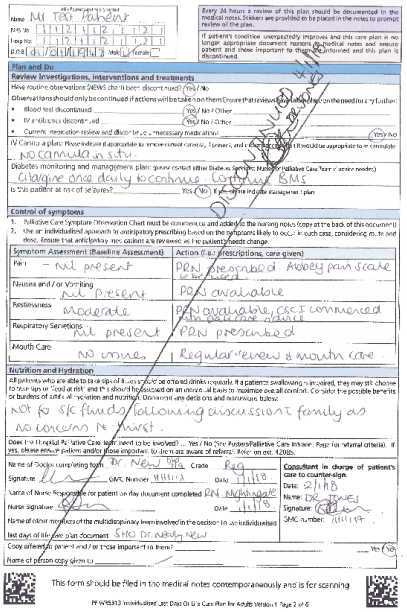
Patient GCS has not improved from 3 since CVA despite supportive treatment.

Discussed with family (son, Kahul) who understand no improvement and for best supportive care.

Hospital

Chaplain and daily to continue comforting BMS

DISCONTINUED 11/1/18

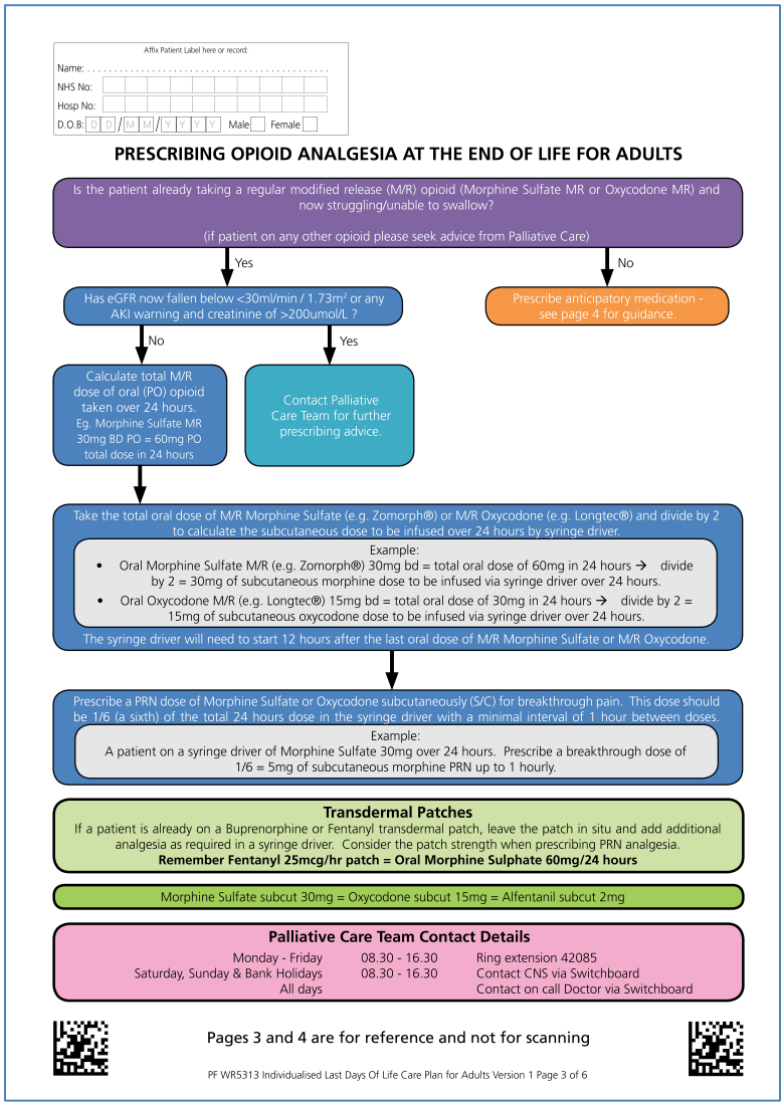


This form should be filed in the medical notes contemporaneously and is for scanning

Other components of the Individualised Last Days of Life Care Plan for Adults

Also included in the Individualised Last Days of Life Care Plan for Adults are two pages (pages three and four) of clinical advice.

1. **Prescribing of Opioid Analgesia at the End of Life for Adults** (page three)



Affix Patient Label here or record:

Name:

NHS No:

Hosp No:

D.O.B: D D / M M / Y Y Y Y Male Female

PRESCRIBING OPIOID ANALGESIA AT THE END OF LIFE FOR ADULTS

Is the patient already taking a regular modified release (M/R) opioid (Morphine Sulfate MR or Oxycodone MR) and now struggling/unable to swallow?

(if patient on any other opioid please seek advice from Palliative Care)

Yes

No

Has eGFR now fallen below <30ml/min / 1.73m² or any AKI warning and creatinine of >200umol/L ?

Prescribe anticipatory medication - see page 4 for guidance.

No

Yes

Calculate total M/R dose of oral (PO) opioid taken over 24 hours. Eg. Morphine Sulfate MR 30mg BD PO = 60mg PO total dose in 24 hours

Contact Palliative Care Team for further prescribing advice.

Take the total oral dose of M/R Morphine Sulfate (e.g. Zomorph®) or M/R Oxycodone (e.g. Longtec®) and divide by 2 to calculate the subcutaneous dose to be infused over 24 hours by syringe driver.

Example:

- Oral Morphine Sulfate M/R (e.g. Zomorph®) 30mg bd = total oral dose of 60mg in 24 hours → divide by 2 = 30mg of subcutaneous morphine dose to be infused via syringe driver over 24 hours.
- Oral Oxycodone M/R (e.g. Longtec®) 15mg bd = total oral dose of 30mg in 24 hours → divide by 2 = 15mg of subcutaneous oxycodone dose to be infused via syringe driver over 24 hours.

The syringe driver will need to start 12 hours after the last oral dose of M/R Morphine Sulfate or M/R Oxycodone.

Prescribe a PRN dose of Morphine Sulfate or Oxycodone subcutaneously (S/C) for breakthrough pain. This dose should be 1/6 (a sixth) of the total 24 hours dose in the syringe driver with a minimal interval of 1 hour between doses.

Example:

A patient on a syringe driver of Morphine Sulfate 30mg over 24 hours. Prescribe a breakthrough dose of 1/6 = 5mg of subcutaneous morphine PRN up to 1 hourly.

Transdermal Patches

If a patient is already on a Buprenorphine or Fentanyl transdermal patch, leave the patch in situ and add additional analgesia as required in a syringe driver. Consider the patch strength when prescribing PRN analgesia.

Remember Fentanyl 25mcg/hr patch = Oral Morphine Sulphate 60mg/24 hours

Morphine Sulfate subcut 30mg = Oxycodone subcut 15mg = Alfentanil subcut 2mg

Palliative Care Team Contact Details

Monday - Friday	08.30 - 16.30	Ring extension 42085
Saturday, Sunday & Bank Holidays	08.30 - 16.30	Contact CNS via Switchboard
All days		Contact on call Doctor via Switchboard

Pages 3 and 4 are for reference and not for scanning

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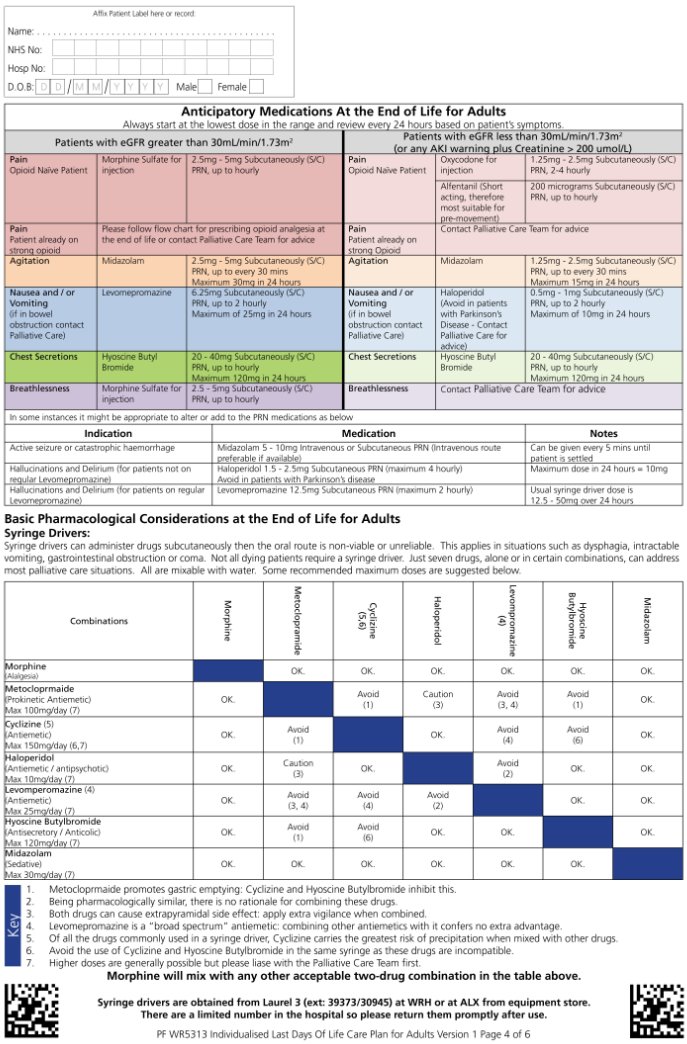
2. **Anticipatory medication at the End of Life for Adults** (page four) – this chart includes prescribing recommendations for patients with normal renal function and separate recommendations for those with renal impairment.

3. **Basic Pharmacological Considerations at the End of Life** (page four) – chart outlining syringe driver drug compatibility.



Affix Patient Label here or record:

Name: . . . . . .

NHS No:

Hosp No:

D.O.B: D D / M M / Y Y Y Y Male Female

Anticipatory Medications At the End of Life for Adults

Always start at the lowest dose in the range and review every 24 hours based on patient's symptoms.

Patients with eGFR greater than 30mL/min/1.73m²			Patients with eGFR less than 30mL/min/1.73m² (or any AKI warning plus Creatinine > 200 umol/L)		
Pain Opioid Naïve Patient	Morphine Sulfate for injection	2.5mg - 5mg Subcutaneously (S/C) PRN, up to hourly	**Pain** Opioid Naïve Patient	Oxycodone for injection	1.25mg - 2.5mg Subcutaneously (S/C) PRN, 2-4 hourly
				Alfentanil (Short acting, therefore most suitable for pre-movement)	200 micrograms Subcutaneously (S/C) PRN, up to hourly
Pain Patient already on strong opioid	Please follow flow chart for prescribing opioid analgesia at the end of life or contact Palliative Care Team for advice		**Pain** Patient already on strong Opioid	Contact Palliative Care Team for advice	
Agitation	Midazolam	2.5mg - 5mg Subcutaneously (S/C) PRN, up to every 30 mins Maximum 30mg in 24 hours	**Agitation**	Midazolam	1.25mg - 2.5mg Subcutaneously (S/C) PRN, up to every 30 mins Maximum 15mg in 24 hours
Nausea and / or Vomiting (if in bowel obstruction contact Palliative Care)	Levomepromazine	6.25mg Subcutaneously (S/C) PRN, up to 2 hourly Maximum of 25mg in 24 hours	**Nausea and / or Vomiting** (if in bowel obstruction contact Palliative Care)	Haloperidol (Avoid in patients with Parkinson's Disease - Contact Palliative Care for advice)	0.5mg - 1mg Subcutaneously (S/C) PRN, up to 2 hourly Maximum of 10mg in 24 hours
Chest Secretions	Hyoscine Butyl Bromide	20 - 40mg Subcutaneously (S/C) PRN, up to hourly Maximum 120mg in 24 hours	**Chest Secretions**	Hyoscine Butyl Bromide	20 - 40mg Subcutaneously (S/C) PRN, up to hourly Maximum 120mg in 24 hours
Breathlessness	Morphine Sulfate for injection	2.5 - 5mg Subcutaneously (S/C) PRN, up to hourly	**Breathlessness**	Contact Palliative Care Team for advice	

In some instances it might be appropriate to alter or add to the PRN medications as below

Indication	Medication	Notes
Active seizure or catastrophic haemorrhage	Midazolam 5 - 10mg Intravenous or Subcutaneous PRN (Intravenous route preferable if available)	Can be given every 5 mins until patient is settled
Hallucinations and Delirium (for patients not on regular Levomepromazine)	Haloperidol 1.5 - 2.5mg Subcutaneous PRN (maximum 4 hourly) Avoid in patients with Parkinson's disease	Maximum dose in 24 hours = 10mg
Hallucinations and Delirium (for patients on regular Levomepromazine)	Levomepromazine 12.5mg Subcutaneous PRN (maximum 2 hourly)	Usual syringe driver dose is 12.5 - 50mg over 24 hours

Basic Pharmacological Considerations at the End of Life for Adults

Syringe Drivers:

Syringe drivers can administer drugs subcutaneously then the oral route is non-viable or unreliable. This applies in situations such as dysphagia, intractable vomiting, gastrointestinal obstruction or coma. Not all dying patients require a syringe driver. Just seven drugs, alone or in certain combinations, can address most palliative care situations. All are mixable with water. Some recommended maximum doses are suggested below.

Combinations	Morphine	Metoclopramide	Cyclizine (5,6)	Haloperidol	Levomepromazine (4)	Hyoscine Butylbromide	Midazolam
Morphine (Analgesia)		OK.	OK.	OK.	OK.	OK.	OK.
Metoclopramide (Prokinetic Antiemetic) Max 100mg/day (7)	OK.		Avoid (1)	Caution (3)	Avoid (3, 4)	Avoid (1)	OK.
Cyclizine (5) (Antiemetic) Max 150mg/day (6,7)	OK.	Avoid (1)		OK.	Avoid (4)	Avoid (6)	OK.
Haloperidol (Antiemetic / antipsychotic) Max 10mg/day (7)	OK.	Caution (3)	OK.		Avoid (2)	OK.	OK.
Levomperomazine (4) (Antiemetic) Max 25mg/day (7)	OK.	Avoid (3, 4)	Avoid (4)	Avoid (2)		OK.	OK.
Hyoscine Butylbromide (Antisecretory / Anticolic) Max 120mg/day (7)	OK.	Avoid (1)	Avoid (6)	OK.	OK.		OK.
Midazolam (Sedative) Max 30mg/day (7)	OK.	OK.	OK.	OK.	OK.	OK.	

Key

1. Metoclopramide promotes gastric emptying: Cyclizine and Hyoscine Butylbromide inhibit this.
2. Being pharmacologically similar, there is no rationale for combining these drugs.
3. Both drugs can cause extrapyramidal side effect: apply extra vigilance when combined.
4. Levomepromazine is a "broad spectrum" antiemetic: combining other antiemetics with it confers no extra advantage.
5. Of all the drugs commonly used in a syringe driver, Cyclizine carries the greatest risk of precipitation when mixed with other drugs.
6. Avoid the use of Cyclizine and Hyoscine Butylbromide in the same syringe as these drugs are incompatible.
7. Higher doses are generally possible but please liase with the Palliative Care Team first.

Morphine will mix with any other acceptable two-drug combination in the table above.

Syringe drivers are obtained from Laurel 3 (ext: 39373/30945) at WRH or at ALX from equipment store.
There are a limited number in the hospital so please return them promptly after use.

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There is also guidance on where syringe drivers can be located on each hospital site at the bottom of page four.

Syringe drivers are obtained from Laurel 3 (ext: 39373/30945) at WRH or at ALX from equipment store.
There are a limited number in the hospital so please return them promptly after use.

For any issues or concerns with advice about clinical management of patients at the end of life the contact details for the Hospital Palliative Care Team (in and out of hours) is at the bottom of the 'prescribing opioid analgesia at the end of life' chart on page three, the bottom of page six (the reverse of the symptom observation chart) and on each of the daily review stickers.

Educational Plan

Initial education plan for introduction of the 'Individualised End of Life Care Plan For Adults'

- Date for commencement of the plan in the Trust : **Week commencing 3rd December 2018**
- Initial Education Plan
  - Drop in face-to-face 40 minute clinical training sessions for all staff
    - Alexandra Hospital – 19th – 23rd November 2018– sessions on the hour between 1000-1400
    - Worcestershire Royal Hospital 26th -30th November 2018 – session on the hour between 1000-1400
  - Face to face 40 minute training session for senior medical staff at
    - Physician's Meeting, Worcestershire Royal Hospital - 19th November 2018
    - Grand Round Meeting, Alexandra Hospital Redditch – 23rd November 2018

For staff attending face-to-face sessions and who complete an attendance sheet providing a valid email address will be sent a certificate of attendance electronically. Advertising for these sessions to be undertaken utilising:

- Desktop backdrops;
- Posters to be distributed onto wards;
- Emailed information using established trust communication methods (such as weekly newsletter.)

Ongoing Educational Plan

Activity	Staff Groups	Frequency
Signposting (10-15minute Palliative Care slot) at Junior Doctor induction	Junior Doctors	Annual (August)
Signposting (utilising the current slot) at Trust Induction	All Staff	Twice a month
Hospital Palliative Care Team information page to be included in hospital trust induction information booklet	All staff	Available to all new staff
Leaflet for distribution at mandatory training (Core clinical Skills days)	Clinical Staff	Annual
Training presentation video to be made available on Palliative Care Team intranet page	All staff	Accessed at time of staff preference. To be available from early December 2018.

Audit (Anticipated audit plan outline)

Following introduction and implementation of the 'Individualised Last Days of Life Care Plan for Adults' clinical audit is planned. The audit will mirror the audit ' ID1435 : To determine the use of Optimising Care as Life Ends (WR 4668) document, used to focus and optimise care for adults where death is expected in WAHT' that was undertaken in July 2017.

Aim:

To explore the use of the WR 5313 document, Individualised Last Days of Life Care Plan for Adults, in patients anticipated to be are in the last days of life.

Objective:

NICE guidelines recommend that an individualised plan of care is in place for each patient recognised as expected to die in a few short days. (NG31, 2015). Auditing the document, newly developed and implemented at WAHT to guide and frame end of life care in the last days of life, will determine the percentage of cases when the document was used to inform patient care, measured against our expectation of 100% compliance of cases where irreversible dying is recognised and death is expected within a few short days. This audit will also evaluate the management of symptoms for end of life patients including consideration and prescribing of anticipatory medications.

It will also measure whether there is increased percentage of compliance using the new document in comparison to previous documents when audited.

Methodology:

20 sequential sets of notes for patients who have had an expected death* at Worcestershire Royal Hospital site and 20 sequential sets of notes for patients who have had an expected death* at Alexandra Hospital, Redditch site. (*expected death is defined as documentation in the medical notes that clearly highlights that death of the patient is anticipated.)

Audit Standards:

- 100% Compliance with the use of 'Individualised Last Days of Life Care Plan For Adults' (Local standard)
- Compliance with guidance on anticipatory prescribing (NICE NG 31)

Planned outline for audits:

Event	Anticipated timescale
Introduction and implementation of 'Individualised Last Days of Life Care Plan For Adults' at Worcestershire Acute Hospital Trust	December 2018
Three month post introduction audit	April 2019
Nine month post introduction audit	September 2019
Ongoing Audit	Thereafter, annually