Mater
Health Services Brisbane Limited

Multidisciplinary Carepath for Palliative Care – End-Stage Care

Carepath Instructions / Information

This tool is a guide to the care of patients who are dying. Once it has been identified that the patient is dying; the goal of care changes from curative management to active but supportive management of physical symptoms, emotional, social, cultural and spiritual needs.
During this time, care is focused on **'quality of life'** of the patient and the **'associated support needs'** of family and close friends/carers who have been identified as significant to the patient. This extends into the initial bereavement period.

Criteria for implementing this carepath:
(The multiprofessional team have agreed that the patient is dying and at least 2 of the following 5 criteria are present)

1. The patient is bedridden
2. The patient has decreasing/fluctuating levels of consciousness
3. The patient is able to tolerate sips of fluid only
4. The patient is no longer able to take tablets
5. The patient is weak and drowsy for extended periods of time

Essential components of care:

1. Comfort Measures	Yes	No	N/A
All non-essential investigations/observations/interventions have been discontinued (e.g. routine blood tests, routine nursing observations, routine imaging)			
Four hourly observations for pain, agitation, nausea & vomiting, and other symptoms are continued			
Non-essential medications have been discontinued			
Essential medications have been charted via an appropriate route (s/c; p.r.; s/l) (e.g. analgesia, , sedatives, anti-emetics and anti-cholinesterase Rx etc. as indicated)			
PRN medications are charted via an appropriate route in anticipation of symptoms **(see table 1 Symptom Management over page)** (e.g. pain, agitation, nausea & vomit, symptoms & anxiety provoking signs related to emergencies (e.g. haemorrhage), retained respiratory secretions, specific symptoms related to type of illness)			

2. Moral / Ethical Issues	Yes	No	N/A
The resuscitation status has been documented			
Any advanced care directive has been acknowledged and copied into the chart			
Organ donation issues (cornea & other organs) have been discussed with patient & family/carers			
Issues surrounding any IV fluids/parenteral feeding/oxygen have been discussed			
The patient has completed a will			
The patient has selected an 'enduring power-of-attorney'			
The patient is dealing with identified 'unfinished business' (including funeral wishes, relationship issues etc.)			

3. Communication	Yes	No	N/A
The Patient's ability to communicate and need for interpreters has been assessed and is being addressed			
The patient is aware of their condition & counselling offered			
The patient's family/carers are aware of the condition and any advance care directives agreed on by patient; family conference has been organised & follow up bereavement arrangements made			
The patient has expressed a preference for who should be present			
Preferred place of death issues have been addressed (hospital, hospice, nursing home, home etc.)			
Financial Issues: Carer's Allowance if at home, Wills, Funeral arrangements & allowances, transport costs to visit etc.			
The patient's family/carers have been given general hospital information (visiting hours, accommodation, dining, toilets, parking, after death procedures, issues with children attending etc.)			
The key contact person and next of kin are identified in the notes with 24 hour contact numbers			
Patient's G.P. & relevant Community Health/Pall care service staff have been contacted			

5. Spiritual/Religious needs	Yes	No	N/A
Spiritual issues have been explored			
Religious needs have been assessed			
Any special needs have been addressed (e.g. speed of burial, washing of body, request for the 'sacrament of the sick', Imam, Rabbi, Priest or other special minister called for, 24hr Pastoral Care number has been given, counselling offered etc.)			

N.B. This care pathway is not irreversible, however any deviation should be discussed with the on-call Palliative Care or other identified Consultant managing this patient's care.

Table 1: Symptom Control Guidelines for the Dying Patient

♦ PAIN

Opioid Naïve Patients	Chart 2.5 – 5 mg morphine subcutaneously (s/c), prn to q2h If more than 2 – 3 doses are required per 24 hours, chart previous 24 hr requirements as a 24 hr continuous s/c infusion (csci)
Patient's already on Morphine:	Chart total daily dose as a 24 hr csci (s/c dose is 1/3 the total oral morphine equivalent) Chart breakthrough dose of 1/6th – 1/10th the total 24 hr s/c dose prn to q2h
Patients on an oral Opioid other than Morphine	Contact palliative care team (PCT) for opioid conversions.
Patients with known renal Impairment	- should be prescribed fentanyl or sufentanil rather than morphine (contact PCT)

♦ AGITATION / TERMINAL RESTLESSNESS

MIDAZOLAM	2.5 – 5 mg s/c/ prn to q2h If more than 2 – 3 doses are required per 24 hours, chart previous 24hr requirements as a 24 hr continuous s/c infusion (csci) (usual dose 10 – 30 mg/24)

♦ NAUSEA / VOMITING

HALOPERIDOL	1.5 mg s/c prn to q8h. If more than 2 – 3 doses are required per 24 hours, chart previous 24hr requirements as a 24 hr continuos s/c infusion (csci) (usual dose 3 - 5 mg / 24 hours)

♦ RETAINED SECRETIONS (NOISY RESPIRATIONS)

GLYCOPYRROLATE	200 – 400 mcg s/c prn to q2h. If more than 2 – 3 prn doses are required, chart as a 24 hr continuous s/c infusion (csci) (usual dose 1.2 – 2.4 mg/24hrs) If symptoms are not controlled, try hyoscine hydrobromide 200 – 400 mcg s/c prn q2h

All patients entered on to the end-stage care pathway must have prn medications charted in anticipation of the above symptoms.

If you have any concerns, please contact a member of the palliative care team through the Mater switch board.

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Palliative Care Restlessness / Agitation Flowchart

Place Identification Sticker here

This is a guideline only. Please continue down the flowchart until symptoms have had an appropriate action put in place

Are there signs of unrelieved pain, i.e. moaning, groaning, facial grimacing?

YES →
- Discomfort may be due to inability to change position – try repositioning the patient
- Administer breakthrough analgesia

NO ↓

Does the patient have a distended bladder or rectum?

YES →
- Consider an indwelling catheter
- If faeces present in rectum, consider PR intervention

NO ↓

Has the patient been incontinent?

YES →
- Clean and dry patient and change linen
- Use incontinent pads or indwelling catheter to maintain a dry, comfortable bed

NO ↓

Are respiratory secretions present?

YES →
- Try repositioning – this may help to shift secretions
- Gently suction secretions if present in the oropharynx
- Consider anticholinergic if noisy secretions present

NO ↓

Does the patient have a dry mouth?

YES →
- Clean patient's mouth with large swabs dipped in sodium bicarbonate solution.
- Moisten oral cavity and lips with a mouth moisturiser or saliva substitute.

NO ↓

Is the patient dyspnoeic?

YES →
- Consider oxygen as prescribed
- Consider morphine SC
- Consider midazolam SC
- Consider Lorazepam SL

NO ↓

Is there a known biochemical imbalance eg. ↑ calicum, ↓ Hb, uraemia?

YES →
- Treatment of an imbalance is usually inappropriate in the terminal phase. Restlessness/agitation should be relieved by using appropriate sedation, e.g. midazolam.

NO ↓

Is the patient febrile and hot to touch?

YES →
- Treatment of an infection is usually inappropriate in the terminal phase Fluctuations in body temp are common due to the dying process. Treat temperature with PR paracetamol, cool sponges and use of fans

NO ↓

Is the patient likely to be experiencing any emotional anguish?

YES →
- Provide a quite environment to reduce stimulation.
- Family carer presence may help relieve anxiety.
- The following may help: Holding hand and speaking gently, hand or neck and shoulder massage, patients favourite music.

→ Contact Palliative Care Liaison for further advice

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Unit Record No: _____

Surname: _____

Given Names: _____

DOB: _____ Sex: _____

AFFIX PT IDENTIFICATION LABEL HERE

Mater Health Services Multidisciplinary Carepath for Palliative Care – End Stage Care

	Date ____/____/____ Ward.....	AM	PM	ND		
EMOTIONAL SUPPORT / SPIRITUAL CARE	Support provided and care discussed with patient / family				Initials	
	Spiritual needs assessed – Pastoral Care referral YES / NO (circle)				Outcome	
	Visited by Pastoral Care / Minister					
RISK ASSESSMENT	Pressure risk assessment score:_____ Falls risk assessment score:_____					
PRESSURE AREA	Pressure Area interventions: _____					
	End Stage Comfort care only ☐ Yes ☐ No					
CONSULTS	Medical (please specify): _____					
	Palliative Care Nurse / Discharge Coordinator (circle)					
	Allied Health (Eg Social Worker, Physiotherapist, O.T. - please specify): _____					
OBSERVATIONS	TPR monitored daily / BD / Nil (circle)				Initials	
	Pain, Agitation, Nausea & Vomit, Respiratory Secretions daily/ BD / Nil (circle)					
	Pain score monitored as per "Pain Observation Chart", patient's score <2				Time	
	Syringe Driver checked 4/24 as per "SC Infusion Chart", infusion rate (mm) is correct					
MEDICATIONS / TREATMENT	O^2 _____ Lt/min via mask / nasal prongs (circle)				Action	
	SC / Syringe Driver / Other _____ (circle)					
	• Site/s checked & resited as per SC infusion forms					
BREAKTHROUGH ORDERS	Breakthrough orders prescribed as necessary for: Pain, Nausea, Respiratory & other Secretions, Restlessness/Agitation					
WOUND CARE	Wound care / Dressings:					
COMFORT / CONSCIOUS STATE (Refer to Palliative Care Restlessness/ Agitation Flowchart included within this carepath)	Chart symptoms					
	• Distressed / Restless / Agitated / Confused / Gurgling / Settled / Drowsy (circle)					
	• Other (please specify): _____					
	Conscious / Rousable / Unconscious (circle)					
	Equipment required Y / N Type (Eg Excel mattress): _____					
	_____					
DIET / NUTRITION	As tolerated / Sips of fluid / Nil by mouth (circle)					
ELIMINATION / CONTINENCE	Incontinent YES / NO (circle) Pads / Urodome / Colostomy YES / NO (circle)				Variance	
	IDC / SPC / Stent / Other _____ insitu (circle) Date inserted ___/___/___					
	Assessment of urinary retention – palpable bladder – Refer to restlessness/Agitation Flowchart					
	Bowel chart completed					
ACTIVITY	RIB / SOOB (circle)					
	Equipment required Y / N Type (Eg hoist): _____					
HYGIENE	Daily sponge / shower attended					
	Equipment required Y / N Type (Eg hoist): _____				Time	
	Mouth care 4/24 or _____; "Mouth Care Chart" YES / NO					

KEY: **Initials** - care attended to; **N/A** - not applicable; **X** – Variance → PLEASE record & sign all variances in the space provided.
Please complete the signature log below.

Printed Name & Position	Signature	Initials	Printed Name & Position	Signature	Initials
RN ND					
RN AM					
RN PM					
DR/ALLIED HEALTH/OTHER					

Disclaimer: Clinical events (including treatment) **must always** be subject to review by a health professional in circumstances where the patients condition and/or the health professionals judgement suggests that a variance in the clinical events on the Carepath is warranted. Each Carepath must be utilised in conjunction with relevant hospital policies and procedures.

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Palliative Care – End Stage Care

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Given Names: _____

DOB: _____ Sex: _____

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Falls Risk Assessment Tool

SCORE	0	1	2	3	DATE: / TIME:
Day since Admission	On Admission	Up to 7 days	8 – 14 days	Over 14 days	
Age	0 – 19 years	20 – 59 years	60 – 70 years	Over 70 years	
Falls History	No falls in the last year	Fall in the last 6 months	Fall in the last 3 months	Fall in the last month	
Balance	Ambulates without assistance/device	Ambulates with assistive device and/or one person	Needs assistance device and 2 people	Chair or bedfast, stand and pivot with help	
Mental State	Oriented to time, place and person	Oriented to place and person	Oriented to person	Disoriented and/or impaired judgment and/or impulsive	
General Health	Well nourished, normal sleep pattern	Poor appetite and/or sleep disturbance	Severe sleep disturbance	Malnourished, weight loss	
Vision	Normal	Wears glasses	Blurred vision, cataract, glaucoma	Severe visual disturbance or blindness	
Speech	Normal	Speech defect but understood	Dysphagia/language barrier	Severe defects or severe language barrier	
Medications	No effectors	CV effectors (beta blocker, diuretic, antihypertensive)	CNS effectors (Tranquilliser, sedative, psychotropic)	Both CV and CNS effectors	
Chronic Illness	None	1 chronic condition	> 1 chronic condition	Multiple illnesses	
Incontinence	None	Increased frequency	Nocturia, stress incontinence	Urge incontinence, indwelling catheter	
				Score	

	INTERVENTIONS	Initial Columns Below (Refer to Signature Log on pressure risk assessment page)
Low Fall Risk Score -0 - 10	Fully orientate the patient to their new surroundings	
	Teach the patient and carers that the bedside table is on wheels and may not support them if leant on	
	Place any walking sicks or frames in a place where they can be easily reached	
	Ensure the bed is at the lowest height appropriate for the patient	
	Ensure the bed brakes are functional and applied	
Medium Fall Risk Score 11 - 20	Discuss the fall risks with the patient and family	
	Consider the need for additional lighting, e.g. night light	
	Assist/supervise the patient when transferring/walking	
	Communicate the risk status to all staff involved in the patient's care	
	Check patient regularly	
	Elimination needs should be assessed every two hours while the patient is awake	
High Fall Risk Score 21 - 33	Reinforce with the patient the need to ask for help from staff when transferring or walking	
	Bedrail assessment and review of alternative strategies	
	Do not leave the patient alone in the bathroom	
	Lights are left on in the bathroom at night	
	Ensure the patient is not left in an isolated position during the day	

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Unit Record No: _____

Surname: _____

Given Names: _____

DOB: _____ Sex: _____

AFFIX PT IDENTIFICATION LABEL HERE

Pressure Risk Assessment Tool (Water Low scale)

			Date:								Date:							
			Time:								Time:							
Build / Weight for Height	Average	0								Continence	Complete / Catheterised	0						
	Above Average	1									Occasional	1						
	Obese	2									Cath/Faecal incontinence	2						
	Below Average	3									Doubly Incontinent	3						
Skin Type Visual Risk Areas	Healthy	0								Sex	Male	1						
	Tissue Paper	1									Female	2						
	Dry	1								Age	14 – 49	1						
	Oedematous	1									50 – 64	2						
	Clammy (Temperature)	1									65 – 74	3						
	Discoloured	2									75 – 80	4						
	Broken / Spot	3									81+	5						
Mobility	Fully	0								Appetite	Average	0						
	Restless / Fidgety	1									Poor	1						
	Apathetic	2									NG Tube / Fluids only	2						
	Restricted	3									NBM / Anorexic	3						
	Inert / Traction	4								Surgery trauma	Orthopaedic Below waist spinal	5						
	Chairbound	5									On Table – 2 hours	5						
Special Risks	Tissue Malnutrition e.g.Cachexia	8								Special Risks	Medications: Steroids, cytotoxics, high dose anti inflammatories	4						
	Cardiac Failure	5									Neurological deficit, e.g. diabetes, MS , CVA, Paraplegic, motor/sensory	5						
	Peripheral Vascular Disease	5																
	Anaemia	2																
	Smoking	1									Subtotal B							
	Subtotal A										Total A and B							
											Initials – see Signature Log below							

Score > 10 At Risk | **Score > 15 High Risk** | **Score > 20 Very High Risk**

Printed Name & Position	Signature	Initials	Printed Name & Position	Signature	Initials

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Mater Health Services –
Oral Assessment Chart

Unit Record No: _____

Surname: _____

Given Names: _____

DOB: _____ **Sex:** _____

AFFIX PT IDENTIFICATION LABEL HERE

Date:												
Time:												
SWALLOW 0 – Normal 1 – Slight difficulty 2 Great difficulty												
LIPS 0 – Normal 1 – Dry/Crusted 2 – Blisters / Sores												
TONGUE 0 – Pink / Moist 1 – Coated 2 – Blistered / Cracked / Bleeding												
CHEEKS 0 – Pink / Moist 1 – Red / coated 2 – Ulcers & / or Bleeding												
GUMS &TEETH 0 – Normal 1 – Debris / Tender 2 – Sore and / or Bleeding												
PALATE 0 – Pink / Moist 1 – Red / Coated 2 – Ulcers / Bleeding												
SALIVA 0 – Moist Mouth 1 – Dry Mouth 2 – Excessive Saliva												
PAIN 0 – No Discomfort 1 – Mild Discomfort 2 – Moderate Pain 3 – Severe Pain												
TOTAL SCORE:												
INITIAL:												

MUCOSITIS MANAGEMENT FLOW CHART

Patient related factors:
-age, nutritional status, pre-existing periodontal disease.

Treatment related factors:
-chemotherapy regimen, XRT

Pre-treatment dental evaluation if possible. Prophylactic anti-viral/anti-fungal medications

Introduce and explain Self Aware Mouth Care Program at commencement of Cancer treatment

MUCOSITIS DEVELOPS:
- careful assessment and documentation
- treatment as per grade of mucositis.

NO MUCOSITIS:
- continue BD general oral hygiene
- continue BD assessment

Grade 1.
- redness, dryness, burning

- BD brushing with soft brush for 90 sec. Rinse and swish with water after brushing.
- 4 hourly swishing with Saline alternate with Sod. Bic. Hold in mouth for at least 30 secs.
- may use sterile water if more comfortable.
- wear full/part dentures as tolerated.

Grade 2.
- very red, white/yellow film, moderate pain
- poor swallow
- dry.sore lips

- continue brushing and rinses as above.
- increase Saline/Sod Bic (or H2O) to 2-3 hourly
- introduce Xylocaine viscous. Nilstat as ordered
- alter diet to soft prn.
- full/part dentures worn for meals only
- note 4/24 temperature. Weigh as ordered

Grade 3.
- visible ulcers, bleeding/necrotic lesions
- debris, thrush patches
- decreased swallow
- poor or no oral intake
- sores/lesions on lips
- severe pain

- BD brushing if possible and platelet count >20
- increase mouth washes to 2 hourly
- analgesia as required
- topical xylocaine/nilstat as ordered
- I.V antibiotics as ordered
- dentures remain out
- supplemental feeding/TPN
- 4/24 temps and daily weight

Sonis, S.T. (1998) Mucositis as a biological process: a new hypothesis for the development of chemotherapy-induced stomatotoxicity. *Oral Oncology* 34:39-43

Wilkes, J. (1998) Prevention and Treatment of Oral Mucositis Following Cancer Chemotherapy. *Seminars in Oncology* 25,5 (Oct) 538-551.