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Contact: CIM@health.qld.gov.au

Queensland Government

Care of the Dying Clinical Pathway (CoDp)

Supporting care in the last hours and days of life

Facility: ....

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

» The CoDp aims to support but **does not replace clinical judgement**
» Care outlined in the CoDp **must be altered if it is not clinically appropriate** for the individual client

» The CoDp is a modified version of the Liverpool Care Pathway for the Dying Patient (LCP) v12
» If you select 'variance', please document in Clinical events / Variance section
» This pathway comprises:
1. Algorithm - decision making in: diagnosing dying and use of the CoDp in the last hours or days of life
2. Initial assessment
3. Ongoing assessment (replaces current nursing care plan)
4. Clinical events / Variance page (replaces current progress notes)
5. Care after death section
6. Relative/carer information sheet

Commencement of the Care of the Dying Clinical Pathway

Must be completed by a Medical Officer (MO) and co-signed by a Registered nurse (RN)

1. **Patient assessed by the multi-disciplinary team (MDT) as being in the last hours or days of life (use the algorithm for diagnosing dying on page 3 to support decision making to commence the CoDp):** ☐ Yes
2. **The patient has a current Acute Resuscitation Plan (ARP) that states that resuscitation is not to be provided:** ☐ Yes

Treating Consultant	Print name:	
Medical Officer	Print name:	Signature:
Registered Nurse	Print name:	Signature:

Date: | Ward: | Time commenced:

Senior Healthcare Professional Endorsement

The decision to use the care of the dying pathway must be endorsed by the **most** senior healthcare professional responsible for the patient's care at the earliest opportunity if different from above.

Name (print):	Signature:	Date:

Multidisciplinary Team (MDT) reassessments (including full formal MDT assessments every three days)

Date:	Time:	Signature:	Date:	Time:	Signature:
Date:	Time:	Signature:	Date:	Time:	Signature:
Date:	Time:	Signature:	Date:	Time:	Signature:

Discontinuation of Care of the Dying Clinical Pathway (complete only if applicable)

☐ **Care of the Dying Clinical Pathway discontinued** ⟶ Date: Time:

Reasons why the Care of the Dying Clinical Pathway was discontinued by MDT:

Decision to discontinue the Care of the Dying Clinical Pathway shared with the:

Patient: ☐ Yes ☐ Variance Relative or carer: ☐ Yes ☐ Variance

References: Ellershaw J. & Wilkinson S. (2011) Care of the dying: a pathway to excellence. 2nd rev ed. Oxford: Oxford University Press. Working party on Clinical Guidelines in Palliative Care (1997) Changing Gear-Guidelines for managing the Last Days of Life in Adults. National Council for Hospice and Specialist palliative care services, London (revised and reprinted January 2005).

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v4.00 - 08/2012
Mat. no.: 10207868
SW270

CARE OF THE DYING CLINICAL PATHWAY

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Health care professional information

- Responsibility for the use of the CoDp document, as part of a continuous quality improvement programme, sits within the governance of an organisation and must be underpinned by a robust education and training program

Aim of the CoDp

- The CoDp document guides healthcare professionals to focus on care in the last hours or days of life. It enables the delivery of high quality care tailored to the patient's individual needs, when their death is expected.

Requirements

- Patients whose care is being supported by the CoDp must be reviewed regularly. This includes regular reflection and critical decision making by all health professionals to ensure decisions are made in the best interest of the patient.
- For the purpose of this CoDp version 4 document – the term best interest includes medical, physical, emotional, social and spiritual and all other factors relevant to the patient's welfare.
- *In addition to regular review, a full formal MDT assessment must be undertaken every 3 days or earlier if required.*
- The recognition and diagnosis of dying is always complex; irrespective of previous diagnosis or history. Uncertainty is an integral part of dying and there are occasions when a patient who is thought to be dying lives longer or dies sooner than expected. Seek a second opinion or specialist palliative care support as needed.
- Occasionally the CoDp may be discontinued. If that patient's condition then deteriorates a new document must be used.
- Good comprehensive clear communication is pivotal and all decisions leading to a change in care delivery should be communicated to the patient where appropriate and to the relative/carer. The views of all concerned must be listened to and documented.

Clinically Assisted Nutrition and Hydration

- The CoDp does not preclude the use of clinically assisted nutrition, hydration or antibiotics. All clinical decisions must be made in the patient's best interest.

Documentation Instructions

- Variances:
  - If a goal on the CoDp is not achieved, this should be coded as a variance. This is not a negative process but demonstrates the individual nature of the patient's condition based on their particular needs, your clinical judgement and the needs of the relative/carer.
  - Document:
    Variance - what was the problem?
    Action - what did you do to address the problem?
    Outcome - what was the result of your action?
- This is a legal document and must be completed as per hospital documentation policy.
- All health professionals must sign the signature log upon initial entry.
- ⊶ **Key** ▲ **Nursing** ■ **Medical** ◆ **Allied Health**
  Symbols guide care to a primary professional stream, it is a visual guide only and its direction is not intended to be absolute.
- Additional CoDp Ongoing Assessment (SW270b) pages are available for extended treatment
- Additional CoDp Clinical Events / Variances (SW270a) pages are available if more space is required for documentation

Developed by RBWH Palliative Care Service and Qld Health Centre for Health Care Improvement

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Signature log (every person documenting in this clinical pathway **must** supply a sample of their initials and signature)

Initials	Signature	Print name	Role

More space available on page 8

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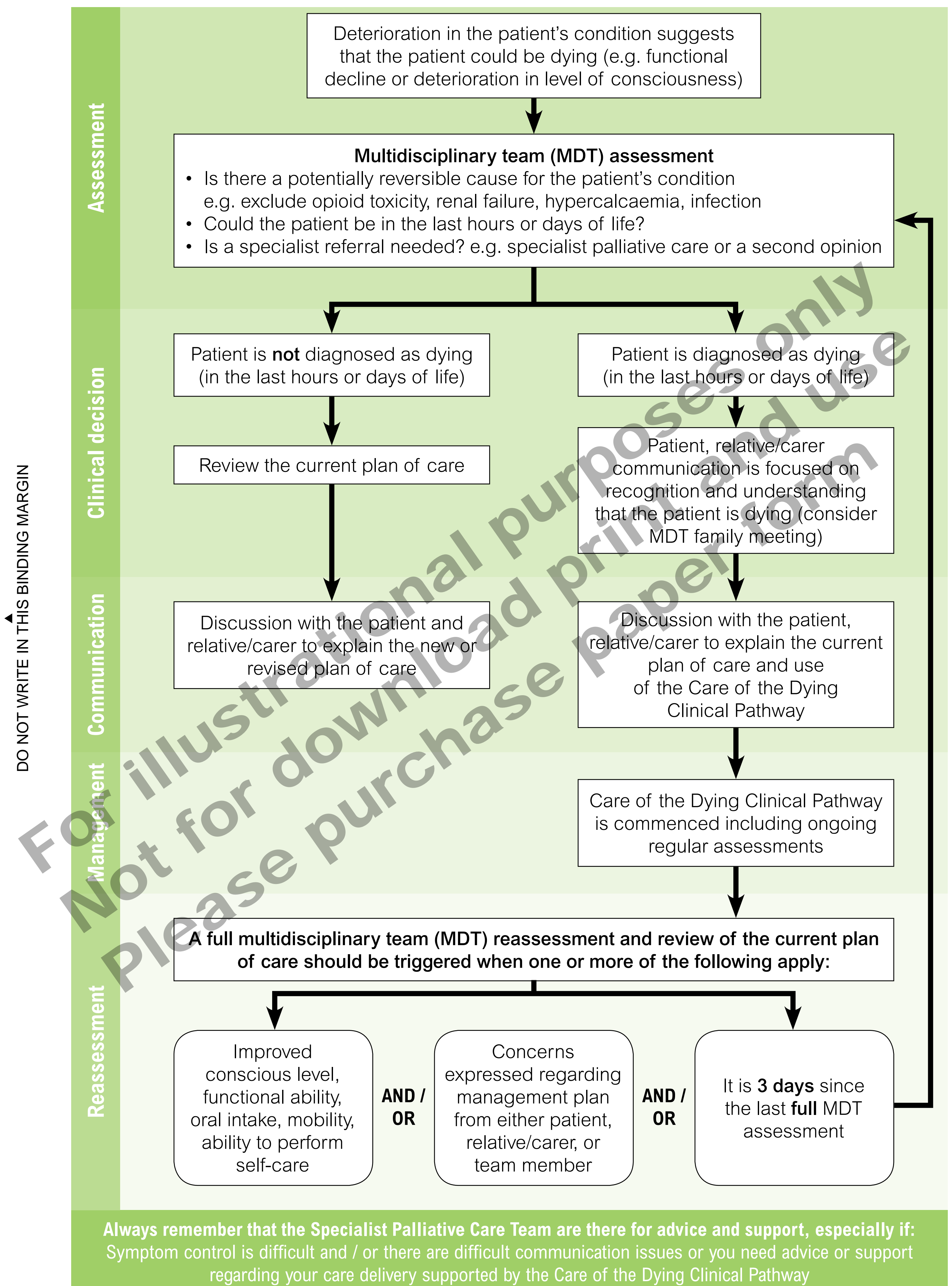
Algorithm - decision making in: diagnosing dying and use of the Care of the Dying Clinical Pathway in the last hours or days of life



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Always remember that the Specialist Palliative Care Team are there for advice and support, especially if:
Symptom control is difficult and / or there are difficult communication issues or you need advice or support regarding your care delivery supported by the Care of the Dying Clinical Pathway

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Initial assessment Joint Assessment by medical officer and nurse (and allied health as required)

Instructions: Initial to indicate goal achieved or enter 'V' to indicate a variance.
If you document a variance 'V', please document in Clinical Events / Variance section.

Key ▲ Nursing ■ Medical ◆ Allied Health

Category	Key	Date of in-patient admission: .... /......... /..............	Initial	V	Date/ time
Diagnosis	■	Primary diagnosis:			
		Associated co-morbidities:			
Baseline information	■	☐ Unable to swallow ☐ Vomiting ☐ Constipated ☐ Confused ☐ Restless ☐ Respiratory tract secretions ☐ Alert ☐ UTI problems ☐ Distressed ☐ Dyspnoea ☐ Pain ☐ Agitated			
Communic-ation	■ ▲	**» Goal 1.1. The patient is able to take a full and active part in communication** ☐ Unconscious • Barriers that have the potential to prevent communication have been assessed • Consider hearing, vision, speech, learning disabilities, dementia (use of assessment tools), neurological conditions and confusion • The relative/carer may know how specific signs indicate distress if the patient is unable to verbalise First language: / Consider need for an interpreter (contact no.): Other barriers to communication / comments:			
		» Goal 1.2. The patient's substitute decision-maker, as documented in the patient's ARP, is able to take a full and active part in communication Name of substitute decision maker: / Relationship to patient: First language: / Consider need for an interpreter (contact no.): Other barriers to communication: Names of other persons present:			
		» Goal 1.3. The patient is aware he/she is dying ☐ Unconscious • Allow time for conversations • Check that the venue is quiet and away from any disruptions • Encourage the patient/family to tell their story • Consider using the Palliative Care Queensland brochure "The Process of Dying" to help facilitate discussions			
		» Goal 1.4. The patient's substitute decision-maker is aware the patient is dying Names of other persons present:			

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Initial assessment Joint Assessment by medical officer and nurse (and allied health as required) (continued)

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Key ▲ Nursing ■ Medical ◆ Allied Health

Category	Key		Initial	V	Date/time
Communic-ation	■ ▲	**» Goal 1.5 The MDT has up to date contact information for the relative/ carer as documented below** *Primary contact person:* Name: / Phone number: Relationship to patient: / Mobile number: *Staying with patient overnight?* ☐ Yes ☐ No *Contact:* ☐ Anytime ☐ Not at night *Secondary contact person:* Name: / Phone number: Relationship to patient: / Mobile number: *Staying with patient overnight?* ☐ Yes ☐ No *Contact:* ☐ Anytime ☐ Not at night			
Facilities	■ ▲ ◆	**» Goal 2 Relative/carer given full explanation of facilities available to them:** • After hours access to the hospital; car parking; tea and coffee facilities • Pay-phones; toilet; arrangements for relatives to stay overnight			
Spiritual / cultural / emotional support	■ ▲ ◆	**» Goal 3.1 Patient given opportunity to discuss what is important at this time (e.g. their wishes, feelings, faith, beliefs and values)** ☐ Unconscious • Patients may be anxious for self or others. Consider specific religious/cultural needs. • Consider music, art, poetry, reading, photographs, something that has been important in their belief system or the well-being of the patient • Did the patient take the opportunity to discuss the above? ☐ Yes ☐ No ☐ Unconscious • Identify and document below any special needs of the patient: Current needs: Needs at death: Needs after death: Patient's ethnicity: • Chaplaincy offered: ☐ Yes, accepted ☐ Yes, declined ☐ Variance Name: / Religion: / Contact no.: • Indigenous Liaison referral required? ☐ Yes ☐ No • Funeral arrangements discussed: ☐ Yes ☐ Variance ☐ Not appropriate			

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Initial assessment **Joint Assessment by medical officer and nurse (and allied health as required)** (continued)

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Key ▲ Nursing ■ Medical ◆ Allied Health

Category	Key		Initial	V	Date/ time
Spiritual / cultural / emotional support	■ ▲ ◆	» **Goal 3.2 Relative/carer given opportunity to discuss what is important at this time (e.g. their wishes, feelings, faith, beliefs and values)** • Did the relative/carer take the opportunity to discuss the above? ☐ Yes ☐ No Comments: • Assess bereavement risk and refer to Social Work / Psychology as required: Name: / Position: / Contact no: • High risk factors: limited social support, emotional distress, family conflict, cumulative losses, sudden or unexpected deterioration			
Medication Consult the palliative care team for advice	■	» **Goal 4.1 - Current medication assessed and nonessentials discontinued:** • Convert appropriate oral drugs to subcutaneous / alternative route			
		» **Goal 4.2 - PRN subcutaneous medication written up for symptoms below:** ☐ Pain ☐ Agitation ☐ Nausea and vomiting ☐ Dyspnoea ☐ Respiratory tract secretions • Anticipatory prescribing is recommended in end-of-life care • Refer to your Organisational Symptom Management Guidelines for advice			
	▲	» **Goal 4.3 - If ordered, continuous subcutaneous infusion (CSCI) set up within 4 hours** ☐ Already in place ☐ Not required • Not all patients will require a continuous subcutaneous infusion. • If a CSCI is to be used, explain the rationale to the patient, relative/carer.			
Current interventions	■	» **Goal 5 - Patient's need for current interventions reviewed by the MDT**			

	Currently not being taken/given	Discontinued	Continued	Commenced
a. Routine blood tests	☐	☐	☐	
b. Intravenous antibiotics	☐	☐	☐	☐
c. Blood glucose monitoring	☐	☐	☐	
d. Recording of routine vital signs	☐	☐	☐	
e. Oxygen therapy	☐	☐	☐	☐

Implantable Cardioverter Defibrillator (ICD) is deactivated (if applicable):
☐ Yes ☐ Variance ☐ N/A

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Key ▲ Nursing ■ Medical ◆ Allied Health

Category	Key		Initial	V	Date/ time
Nutrition	■	» **Goal 6 - Need for clinically assisted (artificial) *nutrition* reviewed by MDT** • The patient should be supported to take food by mouth for as long as tolerated • For many patients the use of clinically assisted (artificial) nutrition will not be required • A reduced need for food is part of the normal dying process • Consider reduction in rate / volume according to individual need if nutritional support is in place • Clinically assisted (artificial) nutrition: ☐ Not required ☐ Discontinued ☐ Continued ☐ Commenced • If in place record route: ☐ NG ☐ PEG / PEJ ☐ NJ ☐ TPN			
Hydration	■	» **Goal 7 - Need for clinically assisted (artificial) *hydration* reviewed by MDT** • The patient should be supported to take fluids by mouth for as long as tolerated • For many patients the use of clinically assisted (artificial) hydration will not be required • A reduced need for fluids is part of the normal dying process • Symptoms of thirst / dry mouth do not always indicate dehydration but are often due to mouth breathing or medication. Good mouth care is essential. • Consider reduction in rate / volume according to individual need if hydration support is in place • If required consider the SC (subcutaneous) route • Clinically assisted (artificial) hydration: ☐ Not required ☐ Discontinued ☐ Continued ☐ Commenced • If in place record route: ☐ IV ☐ SC ☐ PEG / PEJ ☐ NG			
Skin care	▲	» **Goal 8 - Patient's skin integrity assessed** • The goal of pressure area care at this time is primarily to maintain comfort • The frequency of repositioning should be determined by skin inspection, assessment and the patient's individual needs • Consider the use of special aids (mattress/bed) and record the plan of care within the *Ongoing Assessment*			
Explanation of plan of care	■ ▲	» **Goal 9.1 - Full explanation of current plan of care given to the patient** ☐ Unconscious			
		» **Goal 9.2 - Full explanation of current plan of care given to the relative/carer** • Name of persons present (e.g. patient, relative, carer and health professionals): .... • Provide access to age appropriate advice/information to support children/adolescents			
		» **Goal 9.3 - Relative/carer information sheet given** (Tear off the back of the CoDp) • This information sheet aims to support but does not replace sensitive verbal communication about the plan of care			
		» **Goal 9.4 - GP Practice is notified that the patient is dying** • GP to be contacted if unaware that the patient is dying, message can be left or sent via a secure fax			

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Continues from page 2

Initials	Signature	Print name	Role

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Ongoing assessment (complete daily)

Instructions: Initial to indicate goal achieved or enter 'V' to indicate a variance.
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Key ▲ Nursing ◆ Allied Health

Undertake an MDT assessment and review of the current management plan if:

Improved conscious level, functional ability, oral intake, mobility, ability to perform self-care **AND / OR** Concerns expressed regarding management plan from either patient, relative/carer, or team member **AND / OR** It is **3 days** since the last **full** MDT assessment

- Consider the support of the specialist palliative care team and/or a second opinion as required.
- Document all reassessment dates and times on page 1 of this document.

	Date: .... /........ /..............	04:00	08:00	12:00	16:00	20:00	24:00
▲	» **Goal A: The patient does not have pain** • Verbalised by patient if conscious, pain free on movement. • Observe for non-verbal cues. • Consider position change. • Consider PRN analgesia for incident pain. • Consider use of pain assessment tool.						
▲	» **Goal B: The patient is not agitated** • Patient does not display sign of restlessness or distress; exclude reversible causes e.g. retention of urine or opioid toxicity. • Consider position change.						
▲	» **Goal C: Respiratory tract secretions are not distressing the patient** • Consider position change (use semi prone position). • Anticholinergic medication more effective if given as soon as symptom occurs. • Discuss symptom and plan of care with family/other.						
▲	» **Goal D: The patient does not have nausea** • Verbalised by patient if conscious.						
	» **Goal E: The patient is not vomiting**						
▲	» **Goal F: The patient is not breathless** • Verbalised by patient if conscious. • Consider position change and use of fan.						
▲	» **Goal G: The patient does not have urinary problems** • Use of pads, urinary catheter or penile sheath as required.						
▲	» **Goal H: The patient does not have bowel problems** • Monitor for constipation and diarrhoea. Bowels last opened:						
▲	» **Goal I: The patient does not have other symptoms** Record symptoms here (If no other symptoms present, record N/A)						
▲	» **Goal J: The patient's comfort and safety regarding the administration of medications is maintained** • The patient only receives medication that is beneficial at this time. • SC cannula in place for PRN medication and CSCI if required. If CSCI in place complete 4 hourly checks. • *If no medication is required please record N/A*						

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Ongoing assessment (continued)

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Key ▲ Nursing ◆ Allied Health

Key	Date: ..../........../....................	04:00	08:00	12:00	16:00	20:00	24:00
▲	» **Goal K: The patient receives fluids to support their individual needs** • The patient is supported to take oral fluids / thickened fluids for as long as tolerated. • Monitor for signs of aspiration and/or distress. • If appropriate consider clinically assisted (artificial) hydration. If in place monitor and review rate/volume. • Explain the plan of care with the patient, family/other.						
▲	» **Goal L: The patient's mouth is moist and clean** • Frequency of mouth care depends on patient need. • Family/other involved in care giving as appropriate. • Record mouth care products and plan here:						
▲	» **Goal M: The patient's skin integrity is maintained** • The frequency of assessment, repositioning & special aids (e.g. pressure relieving mattress) should be determined by skin inspection and the patient's individual needs. • Record plan of care here:						
▲	» **Goal N: The patient's personal hygiene needs are met** • Skin care; bed sponge; eye care. • Family/other involved in care giving as appropriate.						
▲	» **Goal O: The patient receives their care in a physical environment adjusted to support their individual needs** • Single room; curtains/screens; clean environment; sufficient space at the bedside; consider fragrance; silence; music; lighting; pictures; photographs; nurse call bell accessible.						
▲ ◆	» **Goal P: The patient's psychological well-being is maintained** • Staff just being at the bedside can be a sign of support and caring. Respectful verbal and nonverbal communication; use of listening skills; information and explanation of plan of care given. • Use of touch if appropriate. • Spiritual/cultural/emotional needs supported.						
▲ ◆	» **Goal Q: The well-being of the relative/carer attending the patient is maintained** • Offer food/drink/rest. • Check understanding of all visitors. • Listen and respond to worries and fears; provide age appropriate information. • Use clear language; avoid euphemisms or jargon. • Allow the opportunity to reminisce. • Assess bereavement risk and refer as needed.						

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Please document all multidisciplinary notes within the clinical events / variances notes

Clinical events / variances

Date	Time	Variance code	Expand on variances to clinical pathway for clinical relevance, clinical history, consultations and data collection. Document as **Variance / Action / Outcome**. *(Include name, signature, date and staff category with all entries)*	Initials

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Continue documentation on next page ▶

1 - Patient related	**2 - Staff related**
1.1 - Patient condition	2.1 - Clinician decision
1.2 - Patient choice	2.2 - Other
1.3 - Other	

Queensland Government

Care of the Dying Clinical Pathway (CoDp)

Supporting care in the last hours and days of life

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Please document all multidisciplinary notes within the clinical events / variances notes

Clinical events / variances

Date	Time	Variance code	Expand on variances to clinical pathway for clinical relevance, clinical history, consultations and data collection. Document as **Variance / Action / Outcome**. *(Include name, signature, date and staff category with all entries)*	Initials

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A Care of the Dying Clinical Pathway Clinical Events / Variances (Additional Page) (SW270a) is available if more space is required for clinical events and variances

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Every person documenting in this clinical pathway **must** supply a sample of their initials in the signature log

Verification of patient's death (can be completed by Registered Nurse or Medical Officer)

Date of death: **Time of death:** **Person(s) in attendance:**

General notes on the death (may include quality of death and bereavement risk)

Certification of death documentation (completed by Medical Officer **only**)

Medical officer's name (please print): Signature:

Care after death (this section MUST be completed)

Instructions: If you select 'variance', please document in Clinical Events / Variance section.

Key ▲ Nursing ■ Medical ◆ Allied Health

Category	Key	Date: ..../......../........	Initial	V	Date/ time
Patient Care / Dignity	▲	» **Goal 10 - Last offices are undertaken according to policy and procedure** • The patient is treated with respect and dignity whilst last offices are undertaken • Carry out specific religious / spiritual / cultural requests • Hospital policy followed for patient property			
Relative / Carer Information	■ ▲ ◆	» **Goal 11 - The relative/carer can express an understanding of what they will need to do next and are given relevant written information** • *'Needing Help After Someone Has Died'* (Centrelink publication) booklet given: ☐ Yes ☐ No • *'Understanding Grief'* (The Cancer Council Queensland) booklet given: ☐ Yes ☐ No • Provide information regarding funeral arrangements • Explain viewing procedure as per hospital policy			
Organisational information	■ ▲	» **Goal 12.1 - The primary healthcare team / GP is notified of the patient's death** • If out-of-hours, contact on next working day			
		» **Goal 12.2 - Patient's death is communicated to appropriate services across the organisation** • For example: palliative care team, treating team, allied health professional, outpatients • Input patient's death into hospital computer system as per hospital policy			

Following the death of this patient, do you need any support? Consider seeking support from colleagues.
Support is also available through the Employee Assistance Programme. Phone no.:......................

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The doctors and nurses will have explained to you that there has been a change in your relative or friend's condition. They believe that the person you care about is now dying and in the last days of life.

The dying process is unique to each person but in most cases, a plan of care can be put in place to support the patient, doctors and nurses, relatives/friends to achieve the best quality of care at the end of life.

The Care of the Dying Clinical Pathway is a document which supports the doctors and nurses to give the best quality care. All care will be reviewed regularly.

You and your relative/friend will be involved in the discussion regarding the plan of care with the aim that you fully understand the reasons why decisions are being made. If your relative/friend's condition improves then the plan of care will be reviewed and may be changed. All decisions will be reviewed regularly. If after a discussion with the doctors and nurses you do not agree with any decisions you may want to seek more information.

Communication

There are information leaflets available for you as it is sometimes difficult to remember everything at this sad and challenging time. The doctors and nurses will ask you for your contact details, as keeping you updated is a priority.

Medication/Treatment

Medicine that is not helpful at this time may be stopped and new medicines prescribed. Medicines for symptom control will only be given when needed.

It is often not possible to give medication by mouth at this time, so medication may be given by injection. At times a continuous infusion may be given using a small pump called a Syringe Driver. This will be tailored according to individual needs.

It may not be appropriate to continue some tests at this time; these may include blood tests and or blood pressure and temperature monitoring.

Comfort

Staff will not want to interrupt your time with your relative/friend. However they will make sure that as far as possible any needs at this time are met. Please let them know if you feel those needs are not being met, for whatever reason.

The staff should talk to you about maintaining your relative or friend's comfort; this should include discussion regarding position in bed, use of a special mattress and regular mouth care. You may like to be involved in elements of care at this time and the staff will talk to you about how you can help. You can also support care in important ways such as spending time together, sharing memories and news of family and friends.

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Reduced need for food and drink

Loss of interest in and a reduced need for food and drink is part of the normal dying process. When a person stops eating and drinking it can be hard to accept even when you know they are dying. Your relative/friend will be supported to eat and drink for as long as possible.

Decisions about the use of artificial fluids (a drip) will be made in the best interest of your relative/friend. Fluids given by drip will only be used where it is helpful and not harmful. This decision will be explained to your relative/friend if possible and to you.

Good mouth care is very important at this time. The nurses will explain to you how mouth care is given and may ask if you would like to help them give this care.

Religious/Spiritual needs

The staff will check if you or your relative/friend have a religious tradition or belief and you may want to consider specific support from a chaplain/religious advisor. If you have special needs now or at the time of death or after death please communicate these to the staff.

Caring well for your relative/friend is important to us. Please speak to the staff if you have any questions, regardless of how insignificant you think they may be or how busy the staff may seem. This may all be very unfamiliar to you and we are here to explain, support and care.

We can be reached at:

Other information or contact numbers:

This space can be used to list any questions you may want to ask the staff:

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