MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

INFORMATION FOR HEALTHCARE PROFESSIONALS REGARDING THE LAST DAYS OF LIFE CARE PLAN

RECOGNISE

The recognition of dying is always complex. The possibility that a person may die within the next few days or hours once recognised, needs to be communicated clearly to that person, those important to them and the Multidisciplinary Team (MDT). All decisions made and actions taken are in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly. Use algorithm over the page to support MDT assessment.

COMMUNICATE, INVOLVE AND SUPPORT

Sensitive, comprehensive, clear, communication takes place between staff and the dying person, where possible and appropriate, and those identified as important to them. Shared decisions are made about treatment and care to the extent that the dying person wants.

Where there is no record to the contrary and the person does not have capacity to give consent, it is reasonable to assume that they would want their family and those important to them to be informed about their condition and prognosis.

The possibility that the person may be dying in the coming days or hours is discussed with the person, and with their relative(s), whānau, friend(s) and those identified as important to them. This communication must be conducted in a way that maximises privacy, sensitivity, compassion and is culturally appropriate. The needs of the relatives, whānau and friends are actively explored, respected and met as far as possible.

Staff must check and document the person's (and others who have been involved) understanding of the information that is being communicated.

CREATE AN INDIVIDUALISED CARE PLAN

This individualised care plan is based on the principles of Te Ara Whakapiri and includes the provision of food and drink, symptom control and physical, psychological, social and spiritual support, which is agreed, co-ordinated and delivered with dignity, care and compassion. The care plan is developed using clinical evidence and clinical judgment and discussed with the person and those important to them. Symptom Management Guidelines are provided to support the Last Days of Life Care Plan.

This care plan is generic, for the use in any care setting. Each organisation using this guideline should provide its staff with further guidance as to the organisation's specific requirements, for example the use of electronic clinical records alongside this document, responsibilities for specific sections, times of routine assessments and multidisciplinary review, and contact processes with other professionals involved in the person's care.

REVIEW

The care plan should be dynamic, focussing on assessing the person's condition, needs and wishes and responding appropriately **and reviewed at least daily.**

A full review of current medications is undertaken and non-essentials discontinued. The person should only be receiving medications that are beneficial at this time, with as required medication (prn) prescribed for the most common symptoms at end of life such as pain, respiratory tract secretions, restlessness and agitation, breathlessness, nausea and vomiting.

See algorithm over the page for triggers for full MDT assessment.

REFERENCES:
International Collaborative for Best Care for the Dying Person www.mcpcil.org.uk
Ellershaw J. & Wilkinson S. (2011) Care of the dying: a pathway to excellence. 2nd rev ed. Oxford: Oxford University Press.
Mason S, Dowson J, Gambles M, Ellershaw J. OPCARE9 optimising research for cancer patient care in the last days of life, Eur J Palliative Care 2012;19:17-9
Ellershaw J, Lakhani M. Best Care for the dying patient. BMJ 2013; 347:f4428
Ministry of Health (2015) Te Ara Whakapiri Principles and Guidelines for the Last Days of Life. Wellington: Ministry of Health.

ALGORITHM

Decision making in recognising dying and use of the care plan to support care in the last hours or days of life.

ASSESSMENT

Deterioration in the person's condition suggests that the patient could be dying.

Multidisciplinary Team (MDT) Assessment

- Is there a potentially reversible cause for the person's condition? Eg exclude opioid toxicity, renal failure, hypercalcaemia, infection.
- Is there an advance decision to refuse treatment, Advance Care Plan, Advanced Directive?
- Does the person have the capacity to make their own decisions on their own treatment at this moment in time?
- Is the person being cared for in the most appropriate setting or place of their choice?
- Is a specialist referral needed? For example Specialist Palliative Care or a second opinion.
- Is there an expressed wish for organ/tissue donation?
- The support of an advocate as appropriate.

CLINICAL DECISION

The person is NOT recognised as dying (in the last hours or days of life)

Review the current plan of care

COMMUNICATION

Discussion with the person and relative or carer to explain the new or revised plan of care

The person IS recognised as dying (in the last hours or days of life)

The person (where appropriate) and relative or carer communication is focused on recognition and understanding that the patient is dying

Discussion with the person (where appropriate) and relative or carer to explain the current plan of care

MANAGEMENT

The Last Days of Life Care Plan is commenced including initial, then ongoing regular assessments

REASSESSMENT

A full multidisciplinary team (MDT) reassessment and review of the current plan of care should be triggered when one or more of the following apply:

Improved consciousness level, functional ability, oral intake, mobility, ability to perform self-care

and/or

Concerns expressed regarding management plan from either person, relative or carer or team member

Always remember that the Specialist Palliative Care Teams are available for advice and support, especially if:

Symptom control is difficult and/or if there are difficult communication issues or you need advice or support regarding your care delivery supported by the care plan.

• Arohanui Hospice (06) 356 6606 • Palmerston North Hospital Palliative Care Service: (06) 356 9169 ext 7484 •

MidCentral District Health Board
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PATIENT ID LABEL

BARCODE AREA

LAST DAYS OF LIFE CARE PLAN

Section 1: Initial Assessment

Recognition of Dying

Recognising a person is dying is complex, irrespective of diagnosis or history.

Reversible causes for the person's condition should be assessed and managed (use Health Professional's Information Sheet for guidance).

Where the MDT recognises a person is in their last hours or days of life, they must ensure that the person, their relative, whānau, or friend have the opportunity to understand the possibility that death is imminent.

The following should be considered:

Taha Tinana - Physical Health
SENIOR CLINICIAN TO COMPLETE

Has an Advance Care Plan, Advanced Directive been completed? ☐ Yes ☐ No

and has this been reviewed by the clinical team? ☐ Yes ☐ No

Is this the preferred place of care for the person? ☐ Yes ☐ No

Is this the most appropriate place of care for the person? ☐ Yes ☐ No

If no, has an alternative place of care been discussed with the person, relative, whānau or friend? ☐ Yes ☐ No

If the person is to transfer to another appropriate care setting, has this been organised according to organisational policies and procedures? ☐ Yes ☐ No

To support communication, has written information been given to the relative/whanau/friend such as "What to Expect When Someone is Dying"? ☐ Yes ☐ No

Is the General Practice Team/ARC facility aware the person is dying? ☐ Yes ☐ No

Comments:

Awareness of Person's Changing Condition

Taha Whānau and Taha Hinengaro - Family and Mental Health

First language – consider need for interpreter (contact no):

The person is able to take a full and active part in communication:
☐ Yes ☐ No

The person is aware that they are dying:
☐ Yes ☐ No

The relative, whānau spokesperson or friend* is able to take a full and active part in communication:
☐ Yes ☐ No

The relative, whānau spokesperson or friend* is aware that their relative, whānau member or friend* is dying:
☐ Yes ☐ No

Record outcome of the shared discussion between health professionals and with the person, relative, whānau or friend*

* Included in this list is also advocate and carer.
** Senior clinician refers to most senior clinical doctor or nurse practitioner appropriate to that care setting, eg in ARC this would be general practitioner or nurse practitioner, in acute care setting it would be registrar or consultant.

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Last Days of Life Care Plan Commenced

Date care plan commenced ..... **Time care plan commenced .....**

Name of senior clinician**/lead health practitioner *(record name below)*	Name of nurse *(record name below)*
Print:	Print:
Signature:	Signature:
Next of Kin/Key Spokesperson/EPOA *(please circle and record name below)*	**Relative, whānau or friend* of those present for discussion** *(record names(s) below)*
Name:	Name:
Relationship:	Relationship:

This care plan may be discontinued after discussion with the MDT. If this care plan is discontinued please record here:

Date discontinued ..... Time discontinued .....

Reasons why this care plan was discontinued by MDT Team .....

.....

The person is aware of changing focus of care: ☐ Yes ☐ No

The relative, whānau or friend* is aware of changing focus of care: ☐ Yes ☐ No

Signatures

All personnel completing the care plan please sign below.
You should also have read and understood the 'Health Care Professional Information' on a separate sheet.

Name (print)	Full Signature	Initials	Professional Title	Date

* Included in this list is also advocate and carer.
** Senior clinician refers to most senior clinical doctor or nurse practitioner appropriate to that care setting, eg in ARC this would be general practitioner or nurse practitioner, in acute care setting it would be registrar or consultant.

BINDING MARGIN – NO WRITING

PATIENT ID LABEL

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BINDING MARGIN – NO WRITING

Section 1: Initial Assessment cont...

The clinical team have up to date contact information for the relative, whānau or friend* as documented below

Taha Whānau and Taha Hinengaro - Family and Mental Health

1st contact name .....

Relationship to person ..... Tel no ..... Mobile no .....

When to contact: ☐ At any time ☐ Not at night time ☐ Staying with person overnight

2nd contact name .....

Relationship to person ..... Tel no ..... Mobile no .....

When to contact: ☐ At any time ☐ Not at night time ☐ Staying with person overnight

☐ Next of kin (this may be different from above) or ☐ Enduring Power of Attorney (EPOA) or ☐ Whānau spokesperson

Name ..... Name .....

Contact details ..... Contact details .....

The relative, whānau or friend* has had a full explanation of the facilities and support available to them:
☐ Yes ☐ No

and written information has been given:
☐ Yes ☐ No

Comments:

Base Line Information

Taha Tinana - Physical Health

Conscious state:	☐ Conscious	☐ Semi-conscious	☐ Unconscious	
Alertness:	☐ Fully alert	☐ Confused	☐ Delirious	
In pain:	☐ Yes ☐ No	Dyspnoea:	☐ Yes ☐ No	
Agitated:	☐ Yes ☐ No	Respiratory tract secretions:	☐ Yes ☐ No	
Able to swallow:	☐ Yes ☐ No			
Nauseated:	☐ Yes ☐ No	Vomiting:	☐ Yes ☐ No	
Continent (bladder):	☐ Yes ☐ No	Continent (bowels):	☐ Yes ☐ No	
Catheterised:	☐ Yes ☐ No			
Hygiene needs assessed:	☐ Yes ☐ No	Skin integrity:	☐ Yes ☐ No	
Mouth moist and clean:	☐ Yes ☐ No	Braden score:		
Other symptoms or distress (eg oedema, itch):	☐ Yes ☐ No			

Interventions in the Best Interest of the Person at this Moment in Time

Taha Tinana - Physical Health *SENIOR CLINICIAN TO COMPLETE*

	Currently not being taken/or given	Discontinued	Continued	Commenced
Routine blood tests				
Intravenous antibiotics				
Blood glucose monitoring				
Recording of routine vital signs				
Oxygen therapy				

4.1 Implantable Cardioverter Defibrillator (ICD) is deactivated: ☐ Yes ☐ No ☐ No ICD in place

Contact the person's cardiologist. Refer to local/regional policy/procedure. Written information given to the person, relative, whānau or friend.

PATIENT ID LABEL

Medication

Taha Tinana - Physical Health
SENIOR CLINICIAN TO COMPLETE

Current medication assessed and medications no longer essential for comfort discontinued: ☐ Yes ☐ No

Medication prescribed on an "as required" prn basis for all of the following five symptoms which may develop in the last few days of life:

☐ **Pain** ☐ **Agitation** ☐ **Respiratory tract secretions** ☐ **Nausea/vomiting** ☐ **Dyspnoea**

Anticipatory prescribing will ensure that there is no delay in responding to a symptom. Refer to algorithms at end of care plan.

A syringe driver is available: ☐ **Already in place** ☐ **Is available if required**

If a syringe driver is to be used explain the rationale to the person, relative, whānau, friend*. Not all people who are dying require a syringe driver.

A four hourly checklist should be in place to monitor the use of a syringe driver.

Provision of Food and Fluid

A person should be supported to take fluid and foods by mouth for as long as is safe and tolerated:

Taha Tinana - Physical Health
SENIOR CLINICIAN TO COMPLETE

Is clinically assisted (artificial) **nutrition** required:
☐ Not required ☐ Discontinued ☐ Continued

If clinically assisted (artificial) **nutrition** is already in place please record the route:
☐ NG ☐ PEG/PEJ ☐ NJ ☐ TPN

This review is discussed with the person where possible and appropriate and with the relative, whānau, or friend:
☐ Yes ☐ No

Is clinically assisted (artificial) **hydration** required?
☐ Not required ☐ Discontinued ☐ Continued

If clinically assisted (artificial) **hydration** is already in place please record the route:
☐ IV ☐ SC ☐ PEG/PEJ ☐ NG

This review is discussed with the person where possible and appropriate and with the relative, whānau or friend*:
☐ Yes ☐ No

Comments:

Personalised Care Needs: Spiritual and Cultural

Taha Wairua - Spiritual Health

Ethnicity:
Which ethnic group or groups does the person identify with

.....

It is best practice to ask the person the ethnic groups they identify with.

You can gain important information at this time, for example, someone's iwi or other cultural affiliations that may be important in addressing the goals related to personalising care.

Comments:

The person is given the opportunity to discuss what is important to them at this time, eg their wishes, feelings, faith, beliefs, values and culture.

The relative, whānau spokesperson or friend* is given the opportunity to discuss what is important to them at this time, eg their wishes, feelings, beliefs, values and culture.

Conversations could include identification of specific customs, traditions or cultural practices that are important to the person, relative, whānau or friend at death and after death.

Religious tradition identified, please specify .....

Person's minister/priest/spiritual advisor/tohunga (Maori spiritual advisor) name .....

Phone no ..... Date/time ..... Contacted: ☐ Yes ☐ No ☐ N/A

Support of the facility spiritual advisor: Name .....

Phone no ..... Date/time ..... Contacted: ☐ Yes ☐ No ☐ N/A

The person and their family, whanau, or friends* are aware of the facility cultural support (if available), such as the Māori Health Service, Te Whare Rapuora: ☐ Yes ☐ No ☐ N/A

BINDING MARGIN – NO WRITING

PATIENT ID LABEL

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BINDING MARGIN – NO WRITING

After Death Care Practices

Taha Wairua - Spiritual Health

Are there any specific care practices that the person, family, whānau or friend* want staff to be aware of? Including wishes regarding tissue/organ donation?

☐ Yes ☐ No

Comments:

Checklist

MDT, the person, relative, whānau or friend recognise and agree that person is dying and have been communicated with regarding plan of care:

☐ Yes ☐ No

The person, relative, whānau or friend have agreed to the place of care:

☐ Yes ☐ No

Initial assessment complete:

☐ Yes ☐ No

The person, relative, whānau or friend have been given opportunities for further discussion about the plan of care and are aware this plan of care will be regularly reviewed in consultation with them:

☐ Yes ☐ No

Comments:

PATIENT ID LABEL

Section 2: Ongoing Assessment of the Goals of Care

Date ..... Day .....

Undertake a MDT review of the current care plan. If at any time there is a change in relation to any of the following:

- Improved conscious level, functional ability, mobility, ability to perform self-care.
- Concerns expressed regarding management plan from either the person, relative, whānau or friend or MDT member.

This care plan will be reviewed in its entirety daily.

When each goal is assessed mark with an 'A' if it has been 'achieved'. If interventions are required, mark a "IR" and enter that change on the "Interventions Required Sheet" pg 7.	0400	0800	1200	1600	2000	2400
	If using this in community enter visiting times below					
The person:						
Is pain free						
Is not agitated						
Has no respiratory tract secretions						
Is not breathless						
Is not nauseated						
Is not vomiting						
Has no urinary problems						
Has no bowel problems: Bowels last opened						
Has no other symptoms *(Record symptom here as applicable)*						
Medication and route remain appropriate						
Food and fluid have been provided as appropriate (see question 6 of page 5)						
Has a moist and clean mouth						
Skin integrity is maintained Braden score						
Personal hygiene needs met						
Receives their care in a physical environment adjusted to support their individual needs						
Personalised care needs met (see questions page 5)						
Relatives, whānau or friends*						
Personalised care needs met (see questions page 5)						
Other care needs						
Signature of the registered nurse per shift:	*Night*	*Morning*		*Afternoon*		*Night*

BINDING MARGIN – NO WRITING

PATIENT ID LABEL

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Interventions Required Sheet

Please record intervention required on this sheet.

What occurred?		Interventions taken		Was intervention effective?		If no, what further intervention was taken?	Initials
				Yes	No		
Date:	Time:	Initials:	Time:				
Date:	Time:	Initials:	Time:				
Date:	Time:	Initials:	Time:				
Date:	Time:	Initials:	Time:				
Date:	Time:	Initials:	Time:				
Date:	Time:	Initials:	Time:				
Date:	Time:	Initials:	Time:				

BINDING MARGIN – NO WRITING

PATIENT ID LABEL

Interventions Required Sheet

Please record intervention required on this sheet.

What occurred?		Interventions taken		Was intervention effective?		If no, what further intervention was taken?	Initials
				Yes	No		
Date:	Time:	Initials:	Time:				
Date:	Time:	Initials:	Time:				
Date:	Time:	Initials:	Time:				
Date:	Time:	Initials:	Time:				
Date:	Time:	Initials:	Time:				
Date:	Time:	Initials:	Time:				
Date:	Time:	Initials:	Time:				

BINDING MARGIN – NO WRITING

For additional pages order no: 740089

PATIENT ID LABEL

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Progress Notes

Date/Time	Record significant events/conversations/medical review/significant changes to the person/visits by other specialist teams, eg palliative care/second opinion if sought/person and/or relative, whānau or friend concerns. A summary should be entered each shift.	Print name and signature and role

PATIENT ID LABEL

Progress Notes

Date/Time	Record significant events/conversations/medical review/significant changes to the person/visits by other specialist teams, eg palliative care/second opinion if sought/person and/or relative, whānau or friend concerns. A summary should be entered each shift.	Print name and signature and role

BINDING MARGIN – NO WRITING

PATIENT ID LABEL

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Section 3: Care After Death

Date of person's death ..... Time of person's death ..... ☐ Burial ☐ Cremation

Details of healthcare professional who verified death:

Name ..... *(please print)* Signature .....

Comments .....

Family/whānau present at time of death .....

Persons present at time of death .....

If not present, has the relative, whānau or friend* been notified: ☐ Yes ☐ No

Name of person informed ..... Relationship to the person .....

Name of Funeral Director ..... Telephone no .....

The person is treated with respect and dignity whilst care is undertaken. Universal precautions and local policy and procedures including infection risk are adhered to. Spiritual, religious cultural rituals/needs met. Organisational policy followed for the: • management of ICDs • storage of the person's valuables and belongings. Are valuables left on the person (if requested): ☐ Yes ☐ No	
The relative, whānau or friend can express an understanding of what they will need to do next and are given relevant written information. Conversation with relative, whānau or friend explaining the next steps. Written information is given such as: 'What to Expect When You are Grieving' leaflet given: ☐ Yes ☐ No Information given regarding how and when to contact the funeral director (if appropriate) to make an appointment regarding the death certification and person's valuables and belongings where appropriate: ☐ Yes ☐ No Discuss as appropriate the following: viewing the body/ the need for a post mortem/the need for removal of cardiac devices/the need for a discussion with the coroner: ☐ Yes ☐ No Confirm wishes regarding tissue/organ donation discussed: ☐ Yes ☐ No Information given to families and whānau on child bereavement services where appropriate: ☐ Yes ☐ No	
A private space is available for family/whānau. Arrangements for blessing room/bed space made as appropriate: ☐ Yes ☐ No Karakia/prayer are offered in respect of cultural needs of family/whānau: ☐ Yes ☐ No	
The medical team and/or general practice teams/ARC that supports the person in their usual place of residence are notified of the person's death: ☐ Yes ☐ No	
The person's death is communicated to appropriate services across the organisation: ☐ Yes ☐ No	

PATIENT ID LABEL

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BINDING MARGIN – NO WRITING

PATIENT ID LABEL

BARCODE AREA

PAIN

PATIENT IS IN PAIN

Assess and review cause of pain

Is patient already taking oral morphine?
(If already taking alternative opioid, contact your Specialist Palliative Care Service for advice about conversion.)

YES

1. Consider dose increase of 30% in view of pain.
2. Prescribe PRN doses of morphine, *refer to calculation box •*
3. To convert from oral morphine to subcut, via syringe driver *refer to calculation box* *
4. Assess and review. If pain persists contact your Specialist Palliative Care Service for further advice.

NO

1. If no Contraindications, prescribe & administer morphine 2.5mg – 5mg 4hrly subcut PRN.
2. Review medication. If three or more PRN doses required, then consider continuous infusion or morphine via syringe driver.
3. If pain persists refer to "Yes" box.

PATIENT'S PAIN IS CONTROLLED

Is patient already taking oral morphine?
(If already taking alternative opioid, contact your Specialist Palliative Care Service for advice about conversion.)

YES

1. Prescribe PRN doses of morphine, refer to calculation box •
2. To convert from oral morphine to subcut morphine, via syringe driver refer to calculation box *
3. If pain not controlled refer to 'patient is in pain'.

NO

1. If no contraindications, prescribe morphine 2.5mg – 5mg 4hrly subcut PRN.
2. If pain occurs refer to 'patient is in pain' box.

BINDING MARGIN – NO WRITING

Supporting Information

- To convert from alternative opioid contact Specialist Palliative Care services for advice.
- Review drug, dose, frequency for patients elderly, frail, have dementia or renal failure. Start with lower doses and increase slowly as required.
- Morphine is contraindicated if **GFR is ≤30ml/min** (see pain – for those in renal impairment.

NB:
subcut (subcutaneous)
PRN (as required)

MORPHINE CALCULATIONS

* To convert from oral morphine to morphine subcut via syringe driver, halve the **total 24 hour** dose of oral morphine e.g. 20 mg oral morphine over 24 hours = 10 mg of subcut morphine over 24 hours.

• PRN doses of morphine should be one-sixth of the **24 hour dose** in the syringe driver e.g. morphine 30 mg subcut via a syringe driver will require 5 mg morphine subcut PRN 4 hrly.

Please note: **If you require further advice at any time 24hrs a day please contact Arohanui Hospice – (06) 356 6606.**

Palmerston North Hospital inpatients contact the hospital palliative care service Monday – Friday 8am – 5pm.

PATIENT ID LABEL

For those with Renal Impairment (eGFR≤30)

PAIN

PATIENT IS IN PAIN

Is patient already taking oral opioids?

YES

If patient is already taking strong opioids.
Contact your Specialist Palliative Care Service for advice about choice of opioid.

NO

1. Fentanyl 25 micrograms subcut 2hrly PRN.
2. If three or more doses are required over 24 hours consider starting a syringe driver of fentanyl.
3. Fentanyl 100-250 micrograms in a syringe driver over 24 hours, PRN dose should be 1/8th of the 24hr dose.

EXAMPLE

100 micrograms/24hrs give 12.5 micrograms 1-2 hourly PRN.

200 micrograms/24hrs give 25 micrograms 1-2 hourly PRN.

PATIENT'S PAIN IS CONTROLLED

Is patient already taking oral opioids?

YES

If patient is already taking strong opioids.
Contact your Specialist Palliative Care Service for advice about choice of opioid.

NO

1. Fentanyl 25 micrograms subcut 2hrly PRN.
2. If three or more doses are required over 24 hours consider starting a syringe driver of fentanyl.
3. Fentanyl 100-250 micrograms in a syringe driver over 24 hours, PRN dose should be 1/8th of the 24hr dose.

EXAMPLE

100 micrograms/24hrs give 12.5 micrograms 1-2 hourly PRN.

200 micrograms/24hrs give 25 micrograms 1-2 hourly PRN.

NB:
s/c (subcutaneous)
PRN (as required)

Supporting Information

- To convert from an alternative opioid contact Specialist Palliative Care services for advice.
- Many of the opioid analgesics and their metabolites may accumulate in Renal Failure causing toxicity with myoclonic jerks, profound narcosis and respiratory depression. Morphine and its metabolites are most likely to cause toxicity. Fentanyl is less likely to cause these problems, as the metabolites are not active.
- The duration of effect from morphine and oxycodone may last longer than in a patient with normal renal function.
- **Oxycodone** can be used only with caution if GFR ≤ 20ml/min.

Please note: **If you require further advice at any time 24hrs a day please contact Arohanui Hospice – (06) 356 6606.**

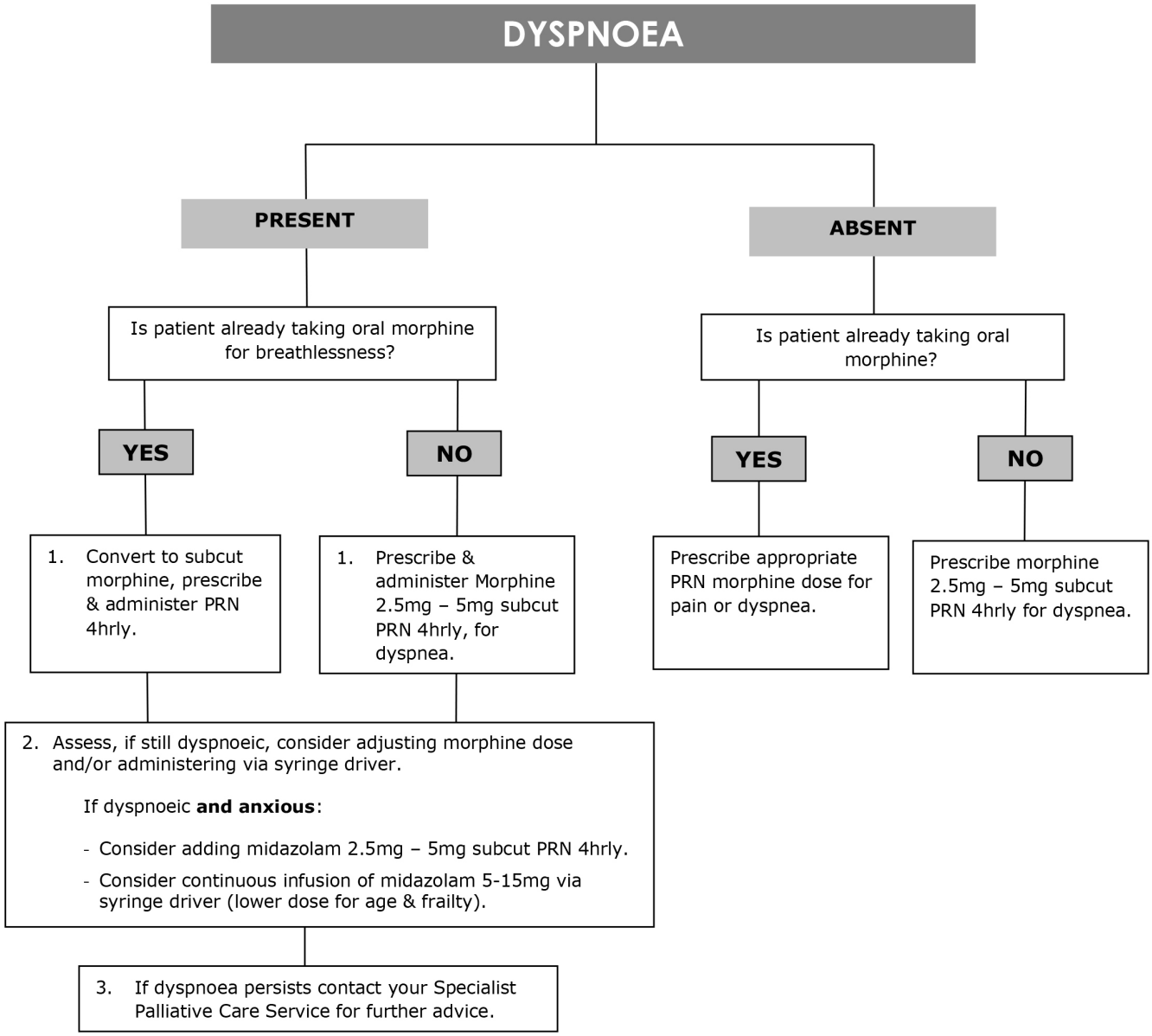
Palmerston North Hospital inpatients contact the hospital palliative care service Monday – Friday 8am – 5pm.

BINDING MARGIN – NO WRITING

PATIENT ID LABEL

BARCODE AREA

Differentiate between dyspnoea, respiratory tract secretions & laboured breathing



BINDING MARGIN – NO WRITING

Supporting Information

- To convert from an alternative opioid contact Specialist Palliative Care services for advice.
- Review drug, dose, frequency for patients elderly, frail, have dementia or renal failure. Start with lower doses and increase slowly as required.

NB:
subcut (subcutaneous)
PRN (as required)

MORPHINE CALCULATIONS

To convert from oral morphine to morphine subcut via syringe driver, halve the total 24 hour dose of oral morphine e.g. 20 mg oral morphine over 24 hours = 10 mg of subcut morphine over 24 hours.

PRN doses of morphine should be one-sixth of the 24 hour dose in the syringe driver e.g. morphine 30 mg subcut via a syringe driver will require 5 mg morphine subcut PRN 4hrly.

Please note: **If you require further advice at any time 24hrs a day please contact Arohanui Hospice – (06) 356 6606.**

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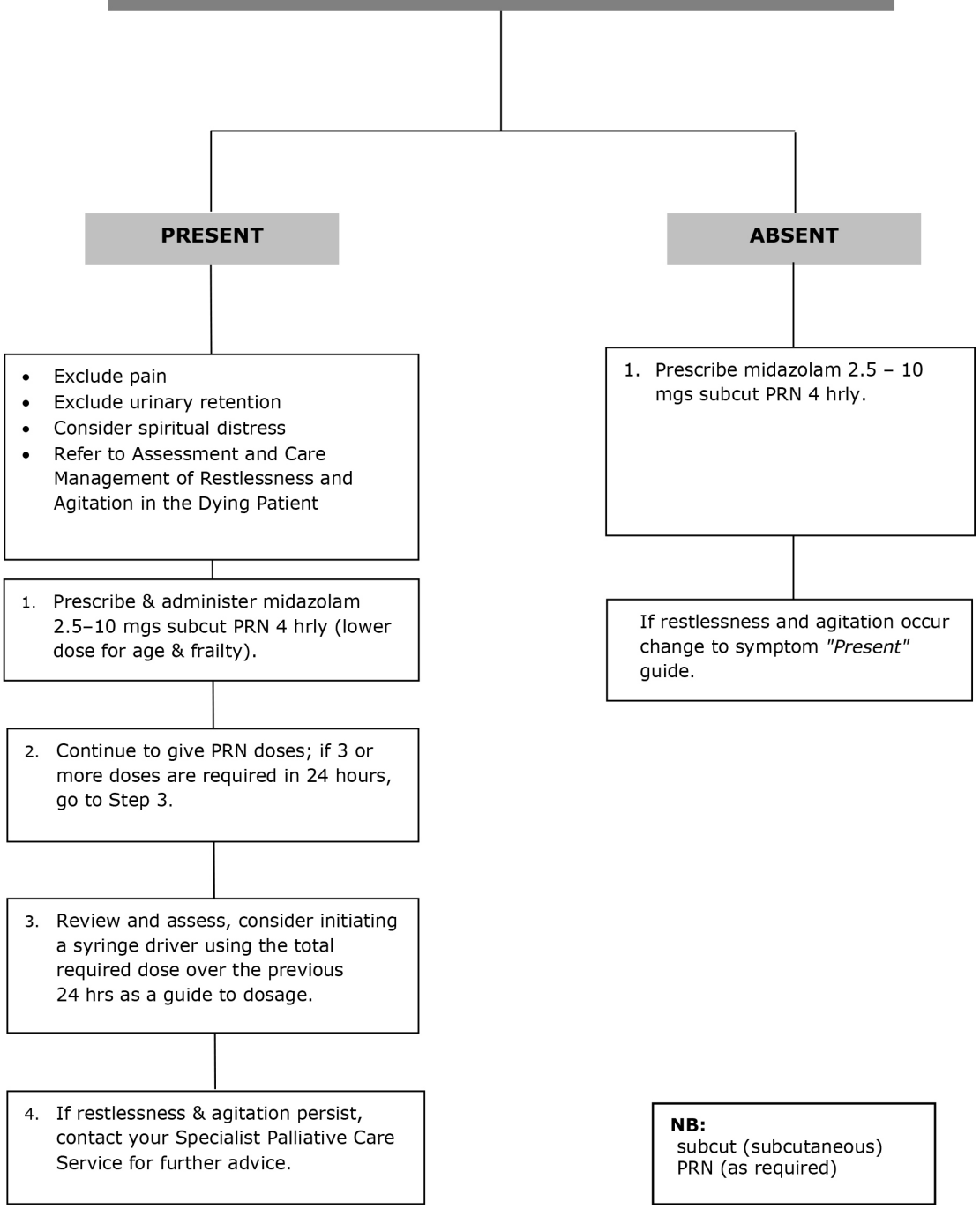
PATIENT ID LABEL

TERMINAL RESTLESSNESS & AGITATION



Supporting Information

- The management of agitation and restlessness does not usually require the use of opioids unless the agitation and restlessness is thought to be caused by pain.
- Review drug, dose, frequency for patients elderly, frail, have dementia or renal failure. Start with lower doses and increase slowly as required.

Please note: **If you require further advice at any time 24hrs a day please contact Arohanui Hospice – (06) 356 6606.**

Palmerston North Hospital inpatients contact the hospital palliative care service Monday – Friday 8am – 5pm.

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RESPIRATORY TRACT SECRETIONS

PRESENT

- Explain symptom to family and whanau.
- Re-position patient.
- If persistent & causing distress move to next step.

1. PRN hyoscine-n-butylbromide 20mgs subcut 4 hourly.

2a. Assess - if symptoms persist and stat dose of hyoscine-n-butylbromide **<u>was</u>** helpful.

Consider syringe driver, with hyoscine-n-butylbromide 60-80 mgs over 24 hours.

2b. Assess - if symptoms persist and stat dose of hyoscine-n-butylbromide **<u>was not</u>** helpful.

Consider prescribing/applying scopolamine TTS x 1 over 72 hours (3 days).

If symptoms persist contact your Specialist Palliative Care Service for further advice.

ABSENT

1. Prescribe scopolamine patch PRN & hyoscine-n-butylbromide 20mgs subcut PRN 4hrly.

If respiratory tract secretions occur change to symptom *"**Present**"* guide.

NB:
subcut (subcutaneous)
PRN (as required)
hyoscine-n-butylbromide = buscopan

BINDING MARGIN – NO WRITING

Supporting Information

- Early intervention may enable more successful management of this symptom.
- Review drug, dose, frequency for patients elderly, frail, have dementia or renal failure. Start with lower doses and increase slowly as required.

Please note: **If you require further advice at any time 24hrs a day please contact Arohanui Hospice – (06) 356 6606**

Palmerston North Hospital inpatients contact the hospital palliative care service Monday – Friday 8am – 5pm.

PATIENT ID LABEL

NAUSEA & VOMITING

PRESENT

1. Prescribe and administer levomepromazine 2.5 – 5.0 mgs subcut PRN 8 hourly.
2. Consider regular administration via syringe driver if symptom persists. i.e. levomepromazine 5.0 mg over 24 hours.
3. Review dosage after 24hrs.
4. If symptoms persist, consider increasing dose i.e. levomepromazine 10.0 mgs over 24hrs via syringe driver.
5. If symptoms persist contact your Specialist Palliative Care Service for further advice.

ABSENT

1. Prescribe levomepromazine 2.5 – 5.0 mgs subcut 8hly PRN.

   Anticipatory prescribing will ensure that there is no delay in responding to a symptom if it occurs.

If symptoms occur change to symptom ***'Present'*** guideline.

NB:
subcut (subcutaneous)
PRN (as required)

Supporting Information

- Levomepromazine can be sedating.
- Review dose for patients who are elderly, frail, have dementia or renal failure (2.5mgs may be more appropriate).

Please note: **If you require further advice at any time 24hrs a day please contact Arohanui Hospice – (06) 356 6606.**

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BINDING MARGIN – NO WRITING