



Name: CHI no: Date:

Codes (please enter in columns) A= Achieved V=Variance (not a signature) If you chart "V" against any goal, please complete variance sheet If patient not symptom free, carry out appropriate intervention and reassess							
<i>Section 2</i>	<i>Patient problem/focus</i> <i>Record time of visit</i>	Date Time	Date Time	Date Time	Date Time	Date Time	Date Time
Ongoing assessment Pain Goal: Patient is pain free <ul style="list-style-type: none"> Verbalised by patient if conscious Pain free on movement Appears peaceful Consider need for positional change 							
Agitation Goal: Patient is not agitated <ul style="list-style-type: none"> Patient does not display signs of delirium, terminal anguish, restlessness (thrashing, plucking, twitching) Exclude retention of urine as cause Consider need for positional change 							
Respiratory tract secretions Goal: Excessive secretions are not a problem <ul style="list-style-type: none"> Medication to be given as soon as symptoms arise Consider need for positional change Symptom discussed with family/other 							
Nausea & vomiting Goal: Patient does not feel nauseous or vomits <ul style="list-style-type: none"> Patient verbalises if conscious 							
Dyspnoea Goal: Breathlessness is not distressing for patient <ul style="list-style-type: none"> Patient verbalises if conscious. Consider need for positional change. 							
Other symptoms (e.g. oedema, itch)							
Treatment/procedures Mouth care Goal: Mouth is moist and clean <ul style="list-style-type: none"> See mouth care policy Mouth care assessment at each visit Frequency of mouth care depends on individual need Family/other involved in care given 							
Micturition difficulties (bladder problems) Goal: Patient is comfortable <ul style="list-style-type: none"> Urinary catheter if in retention Urinary catheter or pads if incontinent 							
Medication (If medication not required please record as N/A) Goal: All medication is given safely & accurately <ul style="list-style-type: none"> If McKinley pump in progress check at each visit according to monitoring sheet 							
Signature							



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<i>Section 2 Continued</i>	<i>Patient problem/focus Record time of visit</i>	Date Time	Date Time	Date Time	Date Time	Date Time	Date Time
Mobility/Pressure area care Goal: Patient is comfortable and in safe environment <ul style="list-style-type: none"> Clinical assessment of: <ul style="list-style-type: none"> Skin integrity Need for positional change Need for special mattress Personal hygiene, bed bath, eye care needs 							
Bowel care Goal: Patient is not agitated or distressed due to constipation or diarrhoea							
Psychological/Insight support Patient Goal: Patient becomes aware of the situation as appropriate <ul style="list-style-type: none"> Patient is informed of procedures Touch, verbal communication is continued 							
Psychological/Insight support Family/other Goal: Family/other are prepared for the patient's imminent death with the aim of achieving peace of mind and acceptance <ul style="list-style-type: none"> Check understanding of nominated family/others / younger adults / children Check understanding of other family/others not present at initial assessment Ensure recognition that patient is dying & of the measures taken to maintain comfort Chaplaincy Team support offered 							
Religious/Spiritual support Goal: Appropriate religious/spiritual support has been given <ul style="list-style-type: none"> Patient/other may be anxious for self/others Support of Chaplaincy Team may be helpful Consider cultural needs 							
Care of the family /others Goal: The needs of those attending the patient are accommodated <ul style="list-style-type: none"> Consider health needs & social support. 							
Health Professional signature each visit							



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Variance analysis

What Variance occurred & why?	Action Taken	Outcome
 Signature..... Date/Time.....	 Signature..... Date/Time.....	 Signature..... Date/Time.....
 Signature..... Date/Time.....	 Signature..... Date/Time.....	 Signature..... Date/Time.....
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Variance analysis

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SECTION 3: Care After Death

Date of death: Time of death:

Persons present:

Notes:

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Signature:

Care after death	Goal 12: GP Practice contacted re patient's death Date __/__/__ A <input type="checkbox"/> V <input type="checkbox"/> <ul style="list-style-type: none"> If out of hours contact on next working day Message can be left with receptionist
	Goal 13: Procedures for laying out followed according to community policy A <input type="checkbox"/> V <input type="checkbox"/> <ul style="list-style-type: none"> Carry out specific religious / spiritual / cultural needs - requests
	Goal 14: Procedure following death discussed or carried out A <input type="checkbox"/> V <input type="checkbox"/> Check for the following: <ul style="list-style-type: none"> Explain mortuary viewing by contacting Funeral Director Family aware cardiac devices (ICD's) or pacemaker must be removed prior to cremation Post mortem discussed as appropriate. Input patients death on community computer system
	Goal 15: Family/other given information on community procedures A <input type="checkbox"/> V <input type="checkbox"/> <ul style="list-style-type: none"> information booklet given to family/other about necessary legal tasks Relatives/other informed to ring Registrars Office to make an appointment
	Goal 16: Community setting only Arrangements in place for the cancellation / uplift of any clinical equipment / supplies / services A <input type="checkbox"/> V <input type="checkbox"/>
	Goal 17: Necessary documentation & advice is given to the appropriate person A <input type="checkbox"/> V <input type="checkbox"/> <ul style="list-style-type: none"> 'What to do after death' booklet given (DHSS)
	Goal 18: Bereavement leaflet given A <input type="checkbox"/> V <input type="checkbox"/> <ul style="list-style-type: none"> Information leaflet on grieving and local support given
	<p>If you have charted "V" against any goal, please complete variance sheet before signing below</p> <p>Health Professional signature: Date:</p>



RESPIRATORY TRACT SECRETIONS

PRESENT

Hyoscine butylbromide (Buscopan®) 20mg sc bolus injection.

Consider 40 – 80mgs via McKinley syringe pump

(Hyoscine hydrobromide 400 micrograms sc may be used but can cause sedation or confusion)

ABSENT

Prescribe hyoscine butylbromide (Buscopan®) 20mg sc hourly prn



NAUSEA AND VOMITING

PRESENT

Consider one of the following:

Haloperidol 2.5 - 5mg/ 24hr via McKinley syringe pump (and 1mg sc prn)

Or

Levomepromazine 5 -20mg / 24hr sc via McKinley syringe pump (and 2.5mg sc prn)

Increase syringe pump dose if 2 or more prn doses needed

If nausea / vomiting not controlled, call the advice line (01236766951)

ABSENT

Prescribe haloperidol 1mg sc 12 hourly prn

Or

Levomepromazine 2.5mg sc 8 – 12 hourly prn



TERMINAL RESTLESSNESS AND AGITATION

PRESENT

If evidence of confusion or hallucinations (e.g. Plucking at bed sheets reaching for invisible objects) give haloperidol 2.5mg sc stat and prn

Consider Haloperidol 2.5 – 5mg/24hr via McKinley syringe pump

If evidence of anxiety or just simple restlessness, give midazolam 2.5mg sc stat and prn

NB. The above drugs can be used together and combined in a McKinley syringe pump.

Doses via McKinley syringe pump should be titrated according to need, if stat doses are helpful.

If agitation is not controlled, call the advice line (01236766951)

ABSENT

Prescribe Haloperidol 2.5mg sc prn for confusion or hallucinations

and

Midazolam 2.5mg sc prn for anxiety or restlessness

Practice Points

- Opioid analgesics should not be used to sedate dying patients
- Benzodiazepines alone do not improve cognition in confusion states and may worsen it



PAIN

If patient is taking strong opioids orally, convert to the subcutaneous route.

To convert from **oral morphine** to:

- A. 24hr sc infusion of morphine
Divide the **total** daily dose of morphine by 2
(e.g. MST 30mgs bd = morphine 30mg / 24hr via syringe pump)
- B. 24hr sc infusion of diamorphine
Divide the **total** daily dose of morphine by 3
(e.g. MST 30mg bd = diamorphine 20mg / 24hr via syringe pump)

To convert from **oral oxycodone** to 24hr sc infusion of oxycodone

- Divide the total daily dose of oxycodone by 2
(e.g. Oxycontin 30mg bd = oxynorm 30mg / 24hr via syringe pump)

PATIENT IS IN PAIN

If on regular strong opioid, offer appropriate sc dose of breakthrough medication (see below)

If not on regular strong opioid, use morphine 2.5mg sc prn. If 2 or more doses needed in 24 hours then consider a McKinley syringe pump (e.g. Morphine 10mgs / 24hr sc)

Review pain control daily.
Consider increase in regular dose if 2 or more breakthrough doses needed.

PATIENT'S PAIN IS CONTROLLED

Ensure sc analgesia is prescribed prn.

If on regular strong opioid, see below for breakthrough doses.

If not on regular strong opioid, prescribe morphine 2.5mg sc prn

Choice of Opioid for use in a Syringe Pump:

- 1st Line: Morphine or Diamorphine
- 2nd Line: Oxycodone
- 3rd Line: Alfentanil (seek specialist advice)

Breakthrough dose should be 1/6 of total daily dose of strong opioid. (e.g. Morphine 90mg sc via syringe pump = morphine 15mg sc prn for breakthrough pain)

For breakthrough dose when using Fentanyl patches, please consult Palliative Care Guidelines or call advice line (01236766951)