INTEGRATED CARE PATHWAY FOR THE DYING PATIENT

PATIENT’S NAME .............................................. UNIT NUMBER ................... DATE ......................

DATE OF BIRTH .................. DATE OF IN PATIENT ADMISSION ..................

DIAGNOSIS: PRIMARY ................................................................. SECONDARY .................................................................

A Care Pathway is intended as a guide to treatment and an aid to documenting patient progress. Of course, practitioners are free to exercise their own professional judgement, however any alteration to the practice identified within this ICP must be noted as a variance on the sheet at the back of the pathway.

CONSULTANT: ............................................................... NAMED NURSE: ............................................................... HOSPITAL: ............................................................... 

G.P.: ............................................................... WARD: ............................................................... 

INSTRUCTIONS FOR USE

1. All goals are in heavy typeface. Interventions, which act as prompts to support the goals, are in normal type.
2. If a goal is not achieved (i.e. variance) then chart on the variance section on the back page
3. The Palliative Care guidelines are printed on the pages at the end of the pathway. Please make reference as necessary.
4. If you have any problems regarding the Pathway contact the Palliative Care Team.

ALL PERSONNEL COMPLETING THE CARE PATHWAY PLEASE SIGN BELOW

<table>
<thead>
<tr>
<th>Name (Print)</th>
<th>Full Signature</th>
<th>Initials</th>
<th>Professional Title</th>
<th>Date</th>
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CRITERIA FOR ICP – DO NOT PUT ON THE PATHWAY UNLESS:

The multiprofessional team have agreed the patient is dying
Intervention for correctable cause has been considered and is not possible/appropriate
and:

The patient is bedbound
Semi-Comatose
Only able to take sips of fluids
No longer able to take tablets

This care pathway is based on the Liverpool Integrated Care Pathway for the Dying Patient NHS Beacon project and the North Cumbria Palliative Care Service

References:
2. Ellershaw et al. (1999) Can hospice based care be transferred into a hospital setting using the Liverpool Care Pathway for the dying patient? Sixth Congress EAPC, Geneva.
## INTEGRATED CARE PATHWAY FOR THE DYING PATIENT

**PATIENT NAME:** ...........................................  **UNIT NO:** .....................  **DATE:** .................................

## SECTION 1: INITIAL PATIENT ASSESSMENT

<table>
<thead>
<tr>
<th>PHYSICAL CONDITION (to be completed by doctor or nurse)</th>
<th>Yes □ No □</th>
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<tbody>
<tr>
<td>Conscious</td>
<td>Yes □ No □</td>
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<tr>
<td>Able to swallow</td>
<td>Yes □ No □</td>
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<tr>
<td>Able to speak</td>
<td>Yes □ No □</td>
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<tr>
<td>Distress</td>
<td>Yes □ No □</td>
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<tr>
<td>Pain</td>
<td>Yes □ No □</td>
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<tr>
<td>Nausea</td>
<td>Yes □ No □</td>
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<tr>
<td>Vomiting</td>
<td>Yes □ No □</td>
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<tr>
<td>Constipation</td>
<td>Yes □ No □</td>
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<tr>
<td>Urinary problems</td>
<td>Yes □ No □</td>
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<tr>
<td>Catheterised</td>
<td>Yes □ No □</td>
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<tr>
<td>Agitation</td>
<td>Yes □ No □</td>
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<tr>
<td>Restlessness</td>
<td>Yes □ No □</td>
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<tr>
<td>Confusion</td>
<td>Yes □ No □</td>
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<tr>
<td>Respiratory tract secretions</td>
<td>Yes □ No □</td>
</tr>
<tr>
<td>Dyspnoea</td>
<td>Yes □ No □</td>
</tr>
<tr>
<td>Other</td>
<td>Yes □ No □</td>
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</tbody>
</table>

## GOALS

(If you chart ‘No’ against any of the goals below, please complete variance sheet on the back page before signing - thank you)

### COMFORT MEASURES (to be completed by doctor)

**Goal 1:** Current medication assessed and non essentials discontinued

- Appropriate oral drugs converted to subcutaneous route and syringe driver commenced if appropriate
- Inappropriate medication discontinued

**Goal 2:** PRN subcutaneous medication written up for list below as per Protocol

- Pain: Analgesia
- Nausea and vomiting: Anti-emetic
- Agitation: Sedative
- Respiratory tract secretions: Anticholinergic

**Goal 3:** Discontinue inappropriate interventions

- Blood Tests
- Antibiotics
- I.V.s (fluids/medications)
- Discuss use of interventions for comfort only (e.g. document CPR status)

---

### COMFORT MEASURES (to be completed by nurse)

**Goal 3a:** Decisions to discontinue inappropriate nursing interventions taken

- Routine Turning Regime (turn for comfort only)
- Taking vital signs

**Goal 3b:** Syringe driver set up within 4 hours of identified need

---

**DOCTOR’S SIGNATURE** .............................................. **DATE** ..............................................

**NURSE’S SIGNATURE** ........................................... **DATE** ........................................... **TIME** ..............

---

**IF YOU HAVE CHARTED “NO” AGAINST ANY GOALS SO FAR, PLEASE COMPLETE VARIANCE SHEET ON THE BACK PAGE BEFORE SIGNING ABOVE –THANK YOU**

---

2
### SECTION 1: INITIAL PATIENT ASSESSMENT (continued)

#### PSYCHOLOGICAL/INSIGHT

**Goal 4:** Ability to communicate in English assessed as adequate

- **Yes □ No □**

  See List of Translators – (********)

#### RELIGIOUS/SPiritual Support

**Goal 6:** Religious/spiritual needs assessed with patient/carer

- **Yes □ No □**

  Formal religion identified: ..........................................................

  **Support:**
  - Church of England ******
  - Roman Catholic Priory, ******
  - Methodist minister, ******

  **Other religious/spiritual support:** (please complete as needed)

  Name: ..........................................................  ☒  .................

  **Special needs now, at time of & after death identified:** (please complete as needed)

#### COMMUNICATION WITH FAMILY/OTHER

**Goal 7:** Identify how family/other are to be informed of patient’s impending death

- **Yes □ No □**

  At any time □  Not at night-time □  Stay overnight at Hospital □

  Primary Contact Name ..........................................................

  Relationship to patient ........................................ Tel no: ...............  

  Secondary contact ........................................ Tel no: ..........................

**Goal 8:** Family/other given hospital information on:-

- **Yes □ No □**

  Car parking; accommodation; availability of refreshments/food; visiting policy; payphones; washrooms & toilet facilities.

  Any other relevant information

#### COMMUNICATION WITH PRIMARY HEALTH CARE TEAM

**Goal 9:** G.P. Practice is aware of patient’s condition

- **Yes □ No □**

  G.P. Practice to be contacted if unaware patient is dying

#### SUMMARY

**Goal 10:** Plan of care explained & discussed with:-

- **Yes □ No □**

  a) Patient □  b) Family □  c) Other □

**Goal 11:** Family/other express understanding of care plan

- **Yes □ No □ N/A □**

**IF YOU HAVE CHARTED “NO” AGAINST ANY GOAL SO FAR, PLEASE COMPLETE VARIANCE SHEET ON THE BACK PAGE BEFORE SIGNING BELOW – THANK YOU**

**Signature:** Health Care Professional..........................  

**Title:** .................  

**Date:** ..............
## INTEGRATED CARE PATHWAY FOR THE DYING PATIENT

**PATIENT NAME:** …………………………….  **UNIT NO:** ………………  **DATE:** ………………….

### SECTION 2: PATIENT CARE

**Enter code in columns:**  A…Achieved  V…Variance

<table>
<thead>
<tr>
<th>FOUR HOURLY PERIOD ENDING:</th>
<th>08:00</th>
<th>12:00</th>
<th>16:00</th>
<th>20:00</th>
<th>24:00</th>
<th>04:00</th>
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</table>

### ASSESSMENT OF PAIN AND OTHER SYMPTOMS

**Pain**
- Goal: Patient is pain free
  - Verbalised by patient if conscious
  - Pain free on movement
  - Appears peaceful
  - Move only for comfort

**Agitation**
- Goal: Patient is not agitated
  - Patient does not display signs of delirium, terminal anguish, restlessness (thrashing, plucking, twitching)
  - Exclude retention of urine as cause

**Respiratory Tract Secretions**
- Goal: Patients breathing is not made difficult by excessive secretions

**Nausea & Vomiting**
- Goal: Patient does not feel nauseous or vomits
  - Patient verbalises if conscious

**Other symptoms (e.g. dyspnoea)**
- a) …………………………………
- b) …………………………………
- c) …………………………………

### TREATMENT/PROCEDURES

**Mouth Care**
- Goal: Mouth is moist and clean.
  - As per local Mouth Care Policy
  - Mouth care to be given at least 4 hourly

**Micturition Difficulties**
- Goal: Patient is comfortable
  - Urinary catheter if in retention
  - Urinary catheter or pads, if general weakness creates incontinence

### MEDICATION (If not appropriate record as N/A)

- Goal: All medication is given safely & accurately.
  - If syringe driver in progress check at least 4 hourly
  - If medication not required please record as N/A

**Nurse’s Signature:**
- Early  Late  Night

---

*Please complete every 4 hours. (Only one A or V needed per box)*

*Please repeat this page each 24 hrs. Spare copies are on ward*

*IF YOU HAVE CHARTED "V" AGAINST ANY GOAL SO FAR, PLEASE COMPLETE VARIANCE SHEET ON THE BACK PAGE BEFORE SIGNING ABOVE – THANK YOU*
**SECTION 2 : PATIENT CARE**

*Please complete 12 hourly. Enter code in columns: A...Achieved  V...Variance*

| MOBILITY/PRESSURE AREA CARE | Goal: Patient is comfortable and in a safe environment  
Patient is moved for comfort only with pressure relieving aids as appropriate e.g. special mattress |
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<tbody>
<tr>
<td>BOWEL CARE</td>
<td>Goal: Patient is not agitated or distressed due to constipation or diarrhoea</td>
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</table>
| PSYCHOLOGICAL/INSIGHT SUPPORT | Patient Goal: Patient becomes aware of the situation as appropriate  
• Patient is informed of procedures  
• Touch, verbal communication is continued  
Family/Other Goal: Family/Other are prepared for the patient’s imminent death with the aim of achieving peace of mind and acceptance  
• Check understanding  
• Recognition of patient dying  
• Inform of measures taken to maintain patient’s comfort  
• Explain possibility of physical symptoms e.g fatigue  
• Explain food and drink are no longer vital  
• Psychological symptoms such as anxiety/depression  
• Social issues such as financial implications |
| RELIGIOUS/SPIRITUAL SUPPORT | Goal: Appropriate religious/spiritual support has been given  
Notes:                                                                                           |
| CARE OF THE FAMILY/OTHERS  | Goal: The needs of those attending the patient are accommodated  
Notes:                                                                                          |

*Please repeat this page each 24 hrs. Spare copies are on ward*

*IF YOU HAVE CHARTED ‘V’ AGAINST ANY GOAL SO FAR, PLEASE COMPLETE VARIANCE SHEET AT THE BACK OF THE PATHWAY BEFORE SIGNING BELOW – THANK YOU*

Nurse’s signature:  
Early  
Late  
Night
### MULTIDISCIPLINARY PROGRESS NOTES
(Please sign and date each entry)

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<tr>
<th>Date</th>
<th>Entry</th>
<th>Signatures</th>
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### SECTION 3: AFTER DEATH

#### VERIFICATION OF DEATH

Date of Death ..................................................  Time of Death ..................................................

Persons Present ..........................................................

Notes ........................................................................

Signature of Nurse/Doctor.............................................  Time Verified .............................................

<table>
<thead>
<tr>
<th>CARE AFTER DEATH CHECKLIST</th>
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<tbody>
<tr>
<td><strong>Goal 12:</strong> GP Practice contacted re patient’s death Date: <strong>/</strong>/__  Yes ☐ No ☐</td>
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<td><strong>Goal 13:</strong> Procedures for laying out followed according to hospital policy Yes ☐ No ☐</td>
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| **Goal 14:** Procedure following death discussed or carried out N/A ☐ Yes ☐ No ☐
  *(If yes please indicate)*
  - Patient had infectious disease ☐
  - Patient has religious needs ☐
  - Post mortem discussed ☐
  - Input patient’s death on hospital computer ☐
| **Goal 15:** Family/other given information about legal formalities after death Yes ☐ No ☐
  - Death certificate issued
  - Family/other informed of where and when to collect death certificate
  - Family/other aware of how to register death
| **Goal 16:** Hospital policy followed for patient’s valuables & belongings Yes ☐ No ☐
  - Belongings listed and put in patient’s property bag
  - Valuables listed and put in sealed envelope in designated locked ward cupboard
| **Goal 17:** Family/other given necessary documentation and advice Yes ☐ No ☐
  - DSS information booklet and Help the Aged booklet
  - Accompanying local information leaflets
| **Goal 18:** Bereavement support Yes ☐ No ☐
  - Discussed, ensure family are aware of Help the Aged bereavement booklet and local information leaflet

Nurse’s Signature: .................................................  Date .................

IF YOU HAVE CHARTED “NO” AGAINST ANY GOAL SO FAR, PLEASE COMPLETE VARIANCE SHEET AT THE BACK OF THE PATHWAY BEFORE SIGNING ABOVE – THANK YOU

*** HAVE YOU COMPLETED THE LAST 4 & 12 HOURLY OBSERVATIONS? ***
## VARIANCE ANALYSIS FOR THE DYING PATIENT

<table>
<thead>
<tr>
<th>DATE</th>
<th>WHAT VARIANCE OCCURRED?</th>
<th>WHY DID VARIANCE OCCUR?</th>
<th>ACTION TAKEN</th>
<th>INITIALS</th>
<th>TITLE</th>
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