

INPATIENT INTEGRATED TERMINAL CARE PATHWAY

ROYAL HOBART HOSPITAL

PT ID									
FAMILY NAME								D.O.B.	
OTHER NAMES								SEX	
ADDRESS								MARITAL STATUS	
								REL.	

This pathway is to be implemented for all patients whose goals of care are terminal. This means that death is ANTICIPATED in days rather than weeks. It relies on 'diagnosing dying'. This is done by assessing a broad range of parameters, the collective presence of which is indicative of dying. A total score of 8 on the chart below is required for the pathway to be activated. The pace of change is also an important consideration, and a trend of irreversibility. However, this is only a guide and clinical judgement always applies.

CATEGORY 1 INDICATOR – MEDICAL (Minor score 2)	Value	Check
Disease progression	2	
End organ failure (liver, kidney, heart, lung)	2	
CATEGORY 2 INDICATOR – FUNCTION (if no Category 1 Score, both Category 2 indicators must apply)		
Bed bound	2	
Decreasing/absent oral intake	2	
MINOR INDICATOR (At least 2 of these indicators must apply)		
Shortness of breath at rest	1	
Confusion	1	
Low serum albumen	1	
Decreased engagement with people and surroundings	1	
'death talk' by patient	1	
'death talk' by family	1	
Future planning that acknowledges dying (eg making a will or funeral plans)	1	
TOTAL MUST BE AT LEAST 8		

Instructions for Use

- Once commenced, the Terminal Care Pathway becomes the SINGLE RECORD OF ONGOING CARE.
- The Goal of Care is comfort during the dying process. The Pathway indicates appropriate assessment and actions to support that goal. Variances should be charted in the variance sections on pages 11 and 12.

Medical Staff to complete:	Section 1. Initial Medical Assessment
Nursing Staff to complete:	Section 2. Initial Nursing Assessment Section 3. Ongoing Assessment
Medical and nursing staff to complete:	Section 4. Record of death and care after death Section 5. Multidisciplinary Progress Notes Section 6. Record of Variance

3. Practitioners are free to exercise their own professional judgement; however, any alteration to the practice identified within this pathway must be noted as a variance.

4. If the patient has been on the Terminal Care Pathway for more than 72 hours and death is not imminent, review of the goals of care may be required.

5. References: For adult palliative care drug formulary, decision making at end of life guidelines, and terminal care guidelines go to http://www.dhhs.tas.gov.au/palliative_care/health_professionals/symptom_management_guidelines

Name (Print) _____	Signature _____
Designation _____	Date _____



FT178340



FT178340

Date commenced: _____

Time: _____

PT ID									
FAMILY NAME								D.O.B.	
OTHER NAMES								SEX	
ADDRESS								MARITAL STATUS	
.....								REL.	

SECTION 1

MEDICAL ASSESSMENT AND CARE PLAN

Diagnosis: _____

Other relevant conditions: _____

A. Assessment – Physical Condition

Unable to swallow	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dyspnoea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Aware	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Conscious	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nausea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Confused	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Restless	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bowel problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Agitated	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Incontinent urine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Twitching	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Catheterised	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Respiratory Secretions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Distressed	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Other: Specify: _____

MEDICAL CARE AND TREATMENT PLAN

B. Comfort Measures

Current medication reviewed:

Inappropriate medication discontinued Yes No

Appropriate oral drugs converted to alternative route Yes No

PRN medication written up for list below (refer to palliative care service guidelines/formulary).

Agitation Sedative Yes No

Pain Analgesic Yes No

Respiratory Tract Secretions Anticholinergic Yes No

Nausea and Vomiting Antiemetic Yes No

Dyspnoea Anxiolytic / Opioid Yes No

Cease the following:

Blood Tests Yes No N/A

Antibiotics Yes No N/A

IV fluids Yes No N/A

IV medications Yes No N/A

Specialist Acute Care Treatments

Cease the following:

X-rays	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Electronic monitoring	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Renal Replacement therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Ventilatory/Oxygen support	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Enteral feeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Physiotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

Other interventions:

Extubate/decannulate trache	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Remove NG tube	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Cardiac defibrillator deactivated	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

Sedation/analgesia route:

IV sedation/analgesia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
sub-cutaneous	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

Other (specify) _____

C: Communication

Care Plan explained, discussed, and understood:

Aware that planned care is now focused on care of the dying	<input type="checkbox"/> Patient	<input type="checkbox"/> Family
Patient's and family's concerns identified and documented	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Patient has an Advance Care Directive	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Patient has named Person Responsible or Enduring Guardian	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Discussion of wishes expressed in Advance Care Directive with:	<input type="checkbox"/> Patient	<input type="checkbox"/> Other

Note below the names of people with whom Care Plan has been discussed:

G.P. is aware of patient's condition.

G.P. to be contacted if unaware patient is dying Yes No

If you have charted "No" against any sections above, please complete variance sheet as attached.

Doctor's Name (Print) _____ Signature _____ Date _____



FT178340

Date commenced: _____

Time: _____

PT ID									
FAMILY NAME								D.O.B.	
OTHER NAMES								SEX	
ADDRESS								MARITAL STATUS	
.....								REL.	

SECTION 2**NURSING CARE PLAN****A. Comfort Measures****Nursing actions:**

- | | | | | |
|--|--------------------------|-----|--------------------------|----|
| Routine turning discontinued – reposition for comfort only | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Patient nursed on pressure relieving mattress | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Measurement of vital signs / routine observations ceased | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Inappropriate charting ceased i.e. fluid balance / blood sugar | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Single room provided if available | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

B. Psychological / Insight**Insight into condition assessed.**

- | | | | | |
|--|--------------------------|-----|--------------------------|----|
| Recognition of dying a) Patient | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Recognition of dying b) Family / other | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

C. Psychosocial Support**Spiritual / religious / cultural / emotional needs assessed and addressed.**

- | | | | | |
|--|--------------------------|-----|--------------------------|----|
| Ability to communicate in English assessed as adequate | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Support of Chaplaincy Team offered | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

Religion if specified: _____

In-house chaplaincy support can be contacted via switch board. External chaplaincy / other support:

Name _____ Contact No _____

- | | | | | |
|--|--------------------------|-----|--------------------------|----|
| Social Work Referral offered (if appropriate) | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Special needs now, at time of and after death identified and documented in multidisciplinary progress notes attached | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

D. Communication with Family / Other

- | | | | | |
|---|--------------------------|-----|--------------------------|----|
| Identification of how family/others are to be informed of impending death. | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
|---|--------------------------|-----|--------------------------|----|

Primary Contact: _____ Relationship to Patient: _____

Telephone: _____ Mobile: _____

- | | | | | |
|----------|--------------------------|---------|--------------------------|--------------|
| Contact: | <input type="checkbox"/> | Anytime | <input type="checkbox"/> | Not at night |
|----------|--------------------------|---------|--------------------------|--------------|

- | | | | | | | |
|--|--------------------------|-----|--------------------------|----|--------------------------|-----|
| Residential Aged Care Facility notified of patient's condition | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | N/A |
|--|--------------------------|-----|--------------------------|----|--------------------------|-----|

D. (cont) Communication with Family / Other

Information provided on hospital facilities and routines

Family made aware of car parking, phones, toilet facilities, and kiosk and cafeteria operating times if available. Yes No

Family given contact phone number Yes No

Family invited to stay overnight Yes No

If you have charted "No" against any sections above, please complete variance sheet as attached.

Further notes if required:

Nurse's Name (Print) _____ Signature _____ Date _____

PT ID									
FAMILY NAME								D.O.B.	
OTHER NAMES								SEX	
ADDRESS								MARITAL STATUS	
								REL.	

Date: _____

NOTE: If the patient has been on Terminal Care Pathway for more than 72 hours and death is not imminent; review of the goals of care may be required.



FT178340

Codes (Enter in Columns) **A = Achieved V = Variance** (not a signature). Insert time of observation in space below

Refer to Ongoing Assessment Guidelines on pages 13 and 14

SYMPTOM ASSESSMENT	GOAL						
Agitation	Patient does not display signs of restlessness or agitation.						
Pain	Patient is pain free						
Respiratory Secretions	Patient's breathing is not distressing due to retained secretions						
Dyspnoea	Patient is not distressed due to breathlessness						
Nausea and Vomiting	Patient does not vomit or feel nauseated						
Other Symptoms							
Specify: _____							
Specify: _____							
COMFORT MEASURES	GOAL						
Mouth Care	Mouth is clean and moist						
Eye Care	Eyes are clean and not dry						
Micturition	Patient is dry and comfortable						
Skin Care	Skin is clean and patient is comfortable						
Bowel Care	Patient is not agitated or distressed due to constipation or diarrhoea						
Medication	All medication is given safely and accurately						
PSYCHOSOCIAL ASSESSMENT	GOAL						
Communication	Verbal / nonverbal communication is continued						
Psychological Support	Patient / family are supported, are involved in decision making and understand patient is dying						
Cultural / Religious / Spiritual Support	Cultural, religious, spiritual needs are identified and rituals are facilitated						
Nurse's initials at bottom of each column of observations							

Repeat this page 24 hourly. If "V" is charted against any goal please complete variance sheet as attached.

Section 3

ONGOING ASSESSMENT

PT ID									
FAMILY NAME								D.O.B.	
OTHER NAMES								SEX	
ADDRESS								MARITAL STATUS	
.....								REL.	

Date: _____

NOTE: If the patient has been on Terminal Care Pathway for more than 72 hours and death is not imminent; review of the goals of care may be required.

Codes (Enter in Columns) **A = Achieved V = Variance** (not a signature). Insert time of observation in space below

Refer to Ongoing Assessment Guidelines on pages 13 and 14

SYMPTOM ASSESSMENT	GOAL						
Agitation	Patient does not display signs of restlessness or agitation.						
Pain	Patient is pain free						
Respiratory Secretions	Patient's breathing is not distressing due to retained secretions						
Dyspnoea	Patient is not distressed due to breathlessness						
Nausea and Vomiting	Patient does not vomit or feel nauseated						
Other Symptoms							
Specify: _____							
Specify: _____							
COMFORT MEASURES	GOAL						
Mouth Care	Mouth is clean and moist						
Eye Care	Eyes are clean and not dry						
Micturition	Patient is dry and comfortable						
Skin Care	Skin is clean and patient is comfortable						
Bowel Care	Patient is not agitated or distressed due to constipation or diarrhoea						
Medication	All medication is given safely and accurately						
PSYCHOSOCIAL ASSESSMENT	GOAL						
Communication	Verbal / nonverbal communication is continued						
Psychological Support	Patient / family are supported, are involved in decision making and understand patient is dying						
Cultural / Religious / Spiritual Support	Cultural, religious, spiritual needs are identified and rituals are facilitated						
Nurse's initials at bottom of each column of observations							

Repeat this page 24 hourly. If "V" is charted against any goal please complete variance sheet as attached.

Section 4 RECORD OF DEATH AND CARE AFTER DEATH

PT ID									
FAMILY NAME								D.O.B.	
OTHER NAMES								SEX	
ADDRESS								MARITAL STATUS	
.....								REL.	

LABEL



Date and Time of Death: _____

Persons Present:

Notes:

Nurse's Name (print): _____ Signature: _____

Medical Notes re Death:

Date and Time: _____

Doctor's Name (print): _____ Signature: _____

Care after Death

Obligatory contacts informed of patient's death

Primary contact (if not present at time of death)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Consultant Date _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
GP Date _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Palliative Care Team Date _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
RACF Date _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

Procedures for laying out carried out according to Hospital policy

Care of the Deceased Patient

Specific religious/ spiritual / cultural requests attended to	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
---	------------------------------	-----------------------------	------------------------------

INPATIENT INTEGRATED TERMINAL CARE PATHWAY

SECTION 7 ONGOING ASSESSMENT GUIDELINES



SYMPTOM	GOAL	PROMPTS
Agitation	Patient does not display signs of restlessness / agitation	<ul style="list-style-type: none"> * Consider urinary retention as a possible reversible cause * Sedative if necessary as ordered
Pain	Patient is pain free	<ul style="list-style-type: none"> * Assessment based on patient's verbal and nonverbal cues * Patient appears peaceful * Analgesia if necessary as ordered * Report uncontrolled pain for adjustment of analgesia dosage
Respiratory Secretions	Patient's breathing is not distressing due to retained secretions	<ul style="list-style-type: none"> * Reposition * Explain aetiology to family * Gentle suction of oral cavity only if necessary and not distressing for / or resisted by patient * Anticholinergic agent if indicated * Mouth care
Dyspnoea	Patient is not distressed due to breathlessness	<ul style="list-style-type: none"> * Fan to increase airflow * Medications as ordered or as per Guidelines * Positioning to enhance breathing * Reassuring presence * Oxygen if necessary for comfort (rarely indicated)
Nausea and Vomiting	Patient does not feel nauseated, or vomiting	<ul style="list-style-type: none"> * Patient verbalises if conscious * Anti-emetic as ordered * Mouth care
COMFORT MEASURES	GOAL	PROMPTS
Mouth Care	Mouth is clean and moist	<ul style="list-style-type: none"> * Regular mouth care * Lubricant to lips * Family educated and encouraged to participate
Eye Care	Eyes are clean and moist	<ul style="list-style-type: none"> * Artificial tears / lubricating ointment if eyes open and patient unconscious
Micturition	Patient is dry and comfortable	<ul style="list-style-type: none"> * Pads checked and changed regularly * Urinary retention considered as a cause of distress * In / out catheter insertion if retention causing discomfort
Skin Care	Patient is comfortable in a safe environment, and interventions are minimised	<ul style="list-style-type: none"> * Personal hygiene is maintained * Sponge in bed if needed, as patient / family desire * Pressure relieving aids used * Reposition for comfort only * Pressure area / wound care dressings reinforced if leaking, changed only if offensive * Leaking oedematous limbs – use incontinence pads
Bowel Care	Patient is not agitated / distressed due to constipation or diarrhoea	<ul style="list-style-type: none"> * Pads checked and changed as necessary * Suppositories only if needed for comfort

PSYCHOSOCIAL ISSUES	GOALS	PROMPTS
Communication	Verbal / Nonverbal communication is continued	<ul style="list-style-type: none"> * Encourage verbal and tactile communication * Patient and family are informed of any procedures * Volunteer to sit with patient if needed
Psychological Support	Patient / family are supported, are involved in decision making and understand patient is dying	<ul style="list-style-type: none"> * Ensure family informed and involved * Facilitate participation in patient care if desired * Address concerns with explanation and reassurance * Be aware of possible anxiety, depression or fatigue
Cultural / Religious / Spiritual Support	Cultural, religious, spiritual needs are identified, rituals are facilitated	<ul style="list-style-type: none"> * Provide opportunity for expression of beliefs, hopes and fears * Facilitate access to cultural / religious / spiritual resources