Covenant Health

Alberta Health Services

STEP ONE Initiate

Palliative Care Pathway (8 hour shifts)

Resident/Patient Label

☐ The interdisciplinary team has agreed that the resident/patient is near end of life **(last hours to days)**. Check those involved:

☐ Physician	☐ RN	☐ LPN	☐ HCA	☐ PT
☐ NP	☐ RT	☐ Dietician	☐ OT	☐ Rec Therapy
☐ Pharmacist	☐ Spiritual Care	☐ SW	☐ RCM	☐ _____

☐ Resident/patient is: *(Must be at least 2 of the following):*

☐ Bedbound
☐ Taking only sips of fluid by mouth
☐ No longer able to take oral medication
☐ Unresponsive

NOTE: Assessment includes the presence of end-stage diseases, decline in cognition, decline in ADL's, and a group of signs and symptoms: dehydration, weight loss, leaving 25% of food uneaten, shortness of breath, and edema.

☐ All possible reversible causes for the resident's/patient's current health status have been addressed:

Yes ☐ No ☐ **If "No" do not proceed with the Pathway**. STOP

☐ The resident/patient has a **Goal of Care Designation of C2,** reviewed with the patient/resident (when possible), family and team**.** ☐ **If not in place, do not proceed with Pathway.** STOP

C2 Order written by_____ (date/time) _____

☐ Personal Directive/Advanced Care Plan completed: ☐ No ☐ Yes

If yes date enacted _____Substitute decision maker's name:_____

☐ **Discussed Pathway care with:**

☐ Resident/Patient: Yes ☐ No ☐ Date_____ Time_____

If "No" give reason _____

☐ Family: Yes ☐ No ☐ Date_____ Time_____

If "No" give reason _____

☐ Substitute Decision Maker/Public Guardian: Yes ☐ No:☐ Date_____ Time_____

If "No" give reason _____

☐ Discussed with Physician/NP: Name _____Date_____ Time_____

☐ **Palliative Care Pathway is the appropriate plan of care, and is initiated by:**

RN/LPN name _____ Date_____ Time_____

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Resident/Patient Label

REASSESSMENT (check all applicable)

Record all interdisciplinary team reassessments here. Reassess appropriateness of the Palliative Care Pathway required every 2-5 days.

Reassessment:

Date, Time, Initials: _____

_____

_____

If the Palliative Care Pathway is discontinued, please record here:

Date, Time, Initials:_____

Reason why: _____

Has the decision to discontinue the Palliative Care Pathway been shared with the resident/patient?

☐ Yes ☐ No

If no, give reason: _____

Has the decision to discontinue the Palliative Care Pathway been shared with the family?

☐ Yes ☐ No

If no, give reason: _____

Has the decision to discontinue the Palliative Care Pathway been shared with the Substitute Decision Maker/ Public Guardian?

☐ Yes ☐ No

If no, give reason: _____

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STEP TWO

INITIAL ASSESSMENT AND IMPLEMENTATION

(check all that apply)

Resident/Patient Label

Physical Condition	☐ Unable to swallow ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Anxiety ☐ Agitation ☐ Febrile ☐ Dehydration ☐ Edema ☐ Dyspnea ☐ Noisy respirations ☐ Pain ☐ Other symptoms _____	Level of Consciousness: ☐ Conscious ☐ Semiconscious ☐ Unconscious

Comfort Measures

Goal 1

Goal 1: Assess current medications and discontinue/adjust as appropriate.

☐ Review the medication profile including route, dosage, and frequency.
☐ Pharmacist: _____ (initial/date)
☐ Physician/NP:_____(initial/date)
☐ Medication orders received: _____(initial/date)

Goal 2

Goal 2: Ensure PRN medications and/or oxygen are ordered for symptom management for:

☐ Pain (Resource Guide A) ☐ Delirium (Resource Guide B) ☐ Noisy Respirations (Resource Guide C) ☐ Nausea & Vomiting (Resource Guide D) ☐ Dyspnea (Resource Guide E)

Goal 3

Goal 3: Discontinue/adjust current interventions as appropriate.
Review and note action taken in Action column
(A – Adjust, D – Discontinue, N/A – Not Applicable):

INTERVENTION	ACTION	COMMENT
☐ Blood Products		
☐ Dialysis		
☐ Deactivate Internal Cardiac Defibrillator		
☐ Diagnostic Tests		
☐ Fluid Therapy (I.V., clysis)		
☐ Enteral Feeding		
☐ Routine Lab Work		
☐ Blood Pressure, Pulse & Temp		
☐ Oxygen Saturation		
☐ Blood Glucose Monitoring		
☐ Weights		
☐ Tub/Shower Bathing		
☐ Other:		

Communication

Goal 4

Goal 4: Assess ability to communicate.

☐ Resident/pt:
☐ English ☐ Preferred Language: _____

☐ Family/Other:
☐ English ☐ Preferred Language: _____

☐ Communication Aides: _____

STEP TWO INITIAL ASSESSMENT (cont'd)

Resident/Patient Label

Nutrition **Goal 5**	**Goal 5: Assess the need for clinically assisted nutrition support.** **The resident/patient will be supported to take food by mouth as long as tolerated.** Current clinically assisted nutrition support route: ☐ N/A ☐ NG ☐ PEG ☐ J-tube ☐ TPN Clinically assisted nutrition support: ☐ Not required ☐ Discontinued ☐ Continued If assisted nutrition support is continued, consider reduction of rate and/or volume. **NOTE: A reduced need for food is part of the normal dying process.**
Hydration **Goal 6**	**Goal 6: Assess the need for clinically assisted hydration.** **The resident/patient will be supported to take fluid by mouth as long as tolerated.** Current clinically assisted hydration support route: ☐ N/A ☐ Clysis ☐ NG ☐ PEG ☐ J-tube Clinically assisted hydration support: ☐ Not required ☐ Discontinued ☐ Continued ☐ Initiated If clinically assisted hydration support is required, consider the subcutaneous route. If clinically assisted hydration support is in place, consider reduction of rate and/or volume. **NOTE: A reduced need for fluids is part of the normal dying process.**
Skin Care **Goal 7**	**Goal 7: Assess the resident's/patient's skin integrity.** **Prevent pressure ulcers or further deterioration of current pressure ulcer.** Braden Scale Score: _____ **or** Pressure Ulcer Risk Score: _____ Pressure Relieving/Positioning Devices Used : _____ Repositioning Schedule Used: _____
Psycho Social Support **Goal 8**	**Goal 8: Assess insight of current condition.** Aware of diagnosis: ☐ Resident/patient ☐ Yes ☐ No Reason: _____ ☐ Family/Other ☐ Yes ☐ No Reason: _____ Aware of prognosis: ☐ Resident /patient ☐ Yes ☐ No Reason: _____ ☐ Family/Other ☐ Yes ☐ No Reason: _____ ☐ N/A describe: _____ ☐ Cultural Needs (describe): _____ _____ ☐ Family Needs i.e. anxiety, anger, divided family (describe): _____ _____ ☐ Social Work referral (date/time): _____ ☐ Other Needs (i.e. military, other affiliations): _____

STEP TWO INITIAL ASSESSMENT (cont'd)

Resident/Patient Label

Spiritual Support **Goal 9**	**Goal 9: Assess spiritual needs of resident/patient and/or family.** ☐ No spiritual interventions requested ☐ Consult Spiritual Care ☐ Resident/patient ☐ Family/Other ☐ Facility: _____ date/time: _____ ☐ Community: _____ date/time: _____ Name: _____ phone #: _____ **Identify specific spiritual concerns or requests (eg Sacraments, Rituals):** ☐ Immediate ☐ At time of impending death: ☐ At death ☐ After death Explain: _____ _____ _____ _____ ☐ Spiritually based/cultural considerations include: _____ _____ ☐ If requested, explain arrangement s: _____ _____ _____
Implement the Palliative Care Pathway **Goal 10**	**Goal 10: Care planned with resident/patient and family/other.** Palliative Care Pathway plan of care reviewed with: ☐ Resident/patient ☐ Yes ☐ No Reason: _____ ☐ Family/Decision Maker/Guardian ☐ Yes ☐ No Reason:_____ Questions and concerns identified and discussed. ☐ Resident/patient ☐ Family/Other ☐ Organ/tissue donation: _____ Information provided: ☐ Yes ☐ No ☐ Designated Funeral Home: _____ **Palliative Care Pathway implemented by:** RN/LPN name:_____Date:_____ Time:_____

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Alberta Health Services

STEP THREE ONGOING ASSESSMENT GOALS OF CARE

Resident/Patient Label

Date: _____

Enter code and initials in each box:
A = Achieved V = Variance *example* A / ID
Document all Variances in Progress Notes
Refer to the Resource Guides Algorithms for Variance management

Resident/patient Problem/Focus	**Q4H**	**0200**	**0600**	**1000**	**1400**	**1800**	**2200**
Pain (Resource Guide A)							
Goal: Resident/patient is comfortable: i.e. Verbalized by resident/patient if able Comfortable with movement Appears comfortable If appears uncomfortable, consider need for positional change or analgesia		**Additional Goal(s)&/or Documentation**					
Delirium (Resource Guide B)							
Goal: Resident/patient is calm and settled: i.e. Does not display signs of restlessness (thrashing, plucking, twitching) Rule out retention of urine, constipation, or opioid toxicity If restless, consider need for positional change		**Additional Goal(s))&/or Documentation**					
Noisy Respirations (Resource Guide C)							
Goal: Respirations are quiet: i.e. Symptoms discussed with family/other If noisy respirations are distressing, consider need for positional change Medication to be given as appropriate		**Additional Goal(s))&/or Documentation**					
Nausea & Vomiting (Resource Guide D)							
Goal: Resident/patient does not feel nauseous and does not vomit: i.e. Resident/patient verbalizes if conscious		**Additional Goal(s))&/or Documentation**					
Dyspnea (Resource Guide E)							
Goal: Breathlessness is not distressing for resident/patient: i.e. Resident/patient verbalizes if conscious If distressing, consider need for positional change		**Additional Goal(s))&/or Documentation**					
Mouth Care (See organizational mouth care policy)							
Goal: Mouth is moist and clean: i.e. Frequency of mouth care depends on individual needs Family/other involved in care given: ☐ Yes ☐ No		**Additional Goal(s))&/or Documentation**					
Urinary Output							
Goal: Resident/patient is comfortable: i.e. Incontinence product utilization Retention Patency of catheter, if applicable		**Additional Goal(s))&/or Documentation**					

STEP THREE ONGOING ASSESSMENT
(cont'd)

Date: _____	**Enter code and initials in each box** **A = Achieved V = Variance** *example* A / TD **Document all Variances in Progress Notes** **Refer to the Resource Guides Algorithms for Variance management**					
Resident/patient Problem/Focus **Q4h**	**0200**	**0600**	**1000**	**1400**	**1800**	**2200**
Hydration & Nutrition						
Goal: The resident/patient receives food nutrition and fluids to support their individual needs. Monitor for signs of aspiration and/or distress. If symptomatically dehydrated and not deemed futile, may consider using hypodermoclysis. If in place, monitor and review rate/volume.	**Additional Goal(s))&/or Documentation**					
Mobility/Skin Care (See organization policy)						
Goal: Resident/patient is comfortable: i.e. Skin integrity Need for positional change Pressure relieving devices Personal hygiene needs i.e. bathing, eye care Clysis site	**Additional Goal(s))&/or Documentation**					
Bowel Care (See organization policy for bowel care)						
Goal: Resident/patient is not agitated due to constipation or diarrhea. ? BM Q2-3days	**Additional Goal(s))&/or Documentation**					
Other Symptoms (e.g. edema, pruritus)						
Specify symptom: _____ **Goal:** _____	**Additional Goal(s))&/or Documentation**					

Resident/Patient Problem/Focus	**Q8H/Shift**	**N**	**D**	**E**
Psychological Support for Resident/Patient				
Goal: Resident/patient is aware of the situation as appropriate. Resident/patient is informed of procedures Touch, verbal communication is continued	**Additional Goal(s) &/or Documentation**			
Psychological Support for Family/Other				
Goal: Family/other are prepared for the resident's/patient's death. Provide update regarding resident's/patient's current condition Review Goals of Care Provide information regarding measures taken to maintain comfort Offer support i.e. Social Work, Spiritual Care	**Additional Goal(s) &/or Documentation**			
Spiritual Support				
Goal: Appropriate spiritual support provided for resident/patient and family/other. Consider faith/cultural needs Offer Spiritual Care support	**Additional Goal(s) &/or Documentation**			
Care of the Family/Others				
Goal: The needs of those attending the resident/patient accommodated. Consider health needs and supports Ensure awareness of facility/community supports	**Additional Goal(s) &/or Documentation**			

STEP FOUR CARE AFTER DEATH

Resident/Patient Label

VERIFICATION OF DEATH

Date of resident's/patient's death: _____Time of resident's/patient's death: _____
Declared deceased by: _____ Date / time: _____
Physician/NP notified ☐ Yes ☐ No Date: _____ Time: _____
Comments: _____
_____
_____

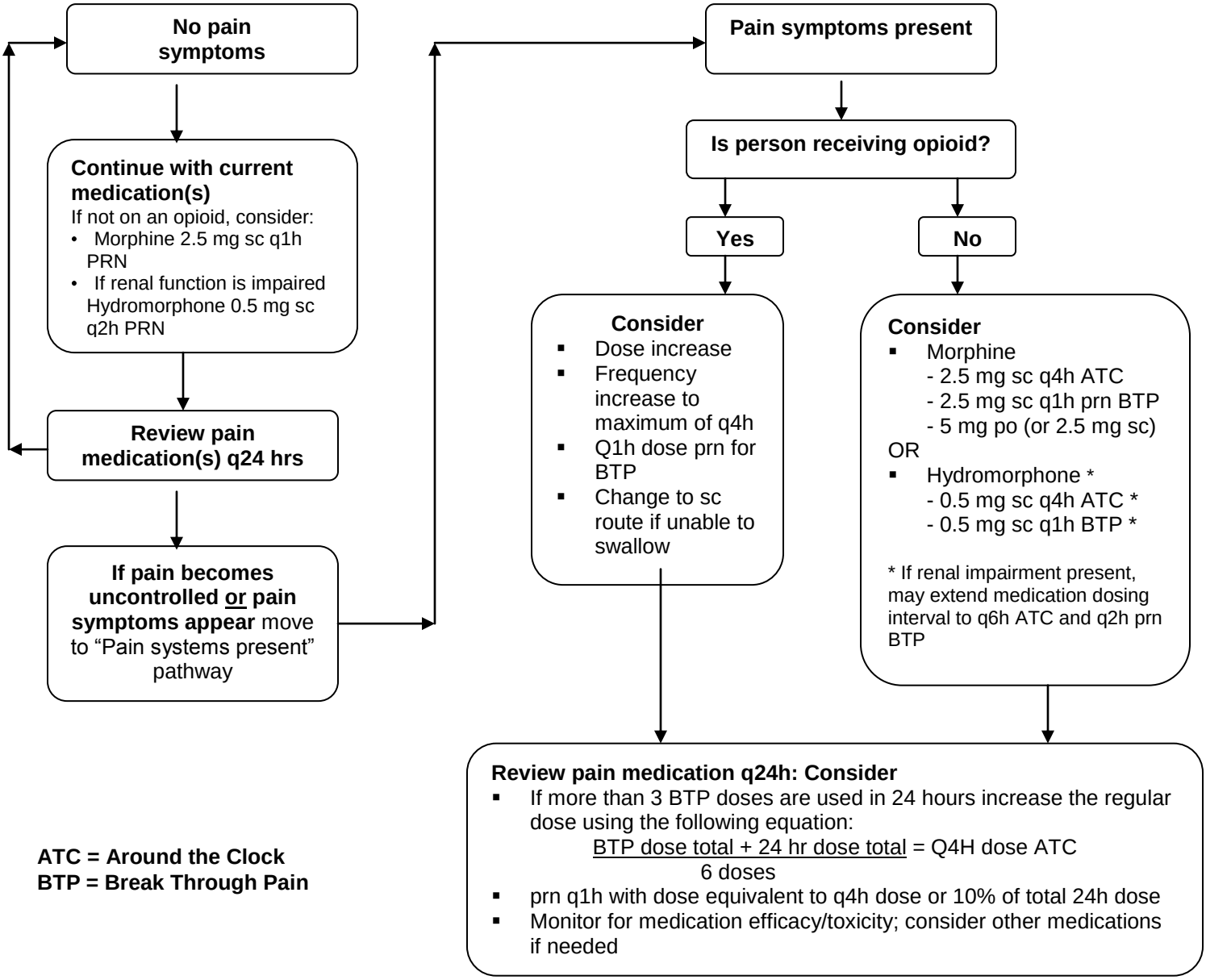
Family/other present at time of death: ☐ Yes ☐ No If not present, family/other notified. ☐ Yes ☐ No
Name of person informed: _____ Relationship to the resident/patient: _____
Coroner Case: ☐ Yes ☐ No
Death Certificate signed: ☐ Yes ☐ No Location of Death Certificate: _____

	Enter code and initials in each box: **A = Achieved V = Variance** *example* A / TD **Document all Variances in Progress Notes**		
Resident/ Patient Care Dignity	**Goal: Post mortem care is provided (Appendix 2)**		
	The resident/patient is treated with respect and dignity during post mortem care. Routine practices and additional precautions are adhered to. Spiritual and cultural rituals/needs met. Organization policy followed for the management and storage of resident/patient valuables and belongings.		
Family/Other Information	**Goal: The family/other can express an understanding of what they will need to do next and given relevant written information.**		
	Conversation held with family/other explaining the next steps. Information given regarding: ▪ contacting the funeral director to make arrangements ▪ retrieving valuables and belongings ▪ tissue/organ donation Discuss as appropriate, viewing the body; the need for a post mortem; the need for a discussion with the coroner. Site specific information given: _____		
Organization Information	**Goal: The resident's/patient's death is communicated to appropriate services**		
	Internal : Business Office _____ Dietary Services_____ Rehab _____ Social Work_____ Spiritual Care _____ Pharmacy _____Other _____ External: Palliative Care Program (where appropriate) _____ Other: _____ Body released to: _____ Date/time;_____		

Date: _____ **Time:** _____ **Signature:** _____

Medication for End Of Life Symptom Management

RESOURCE GUIDE A: Pain



ATC = Around the Clock
BTP = Break Through Pain

NOTE:

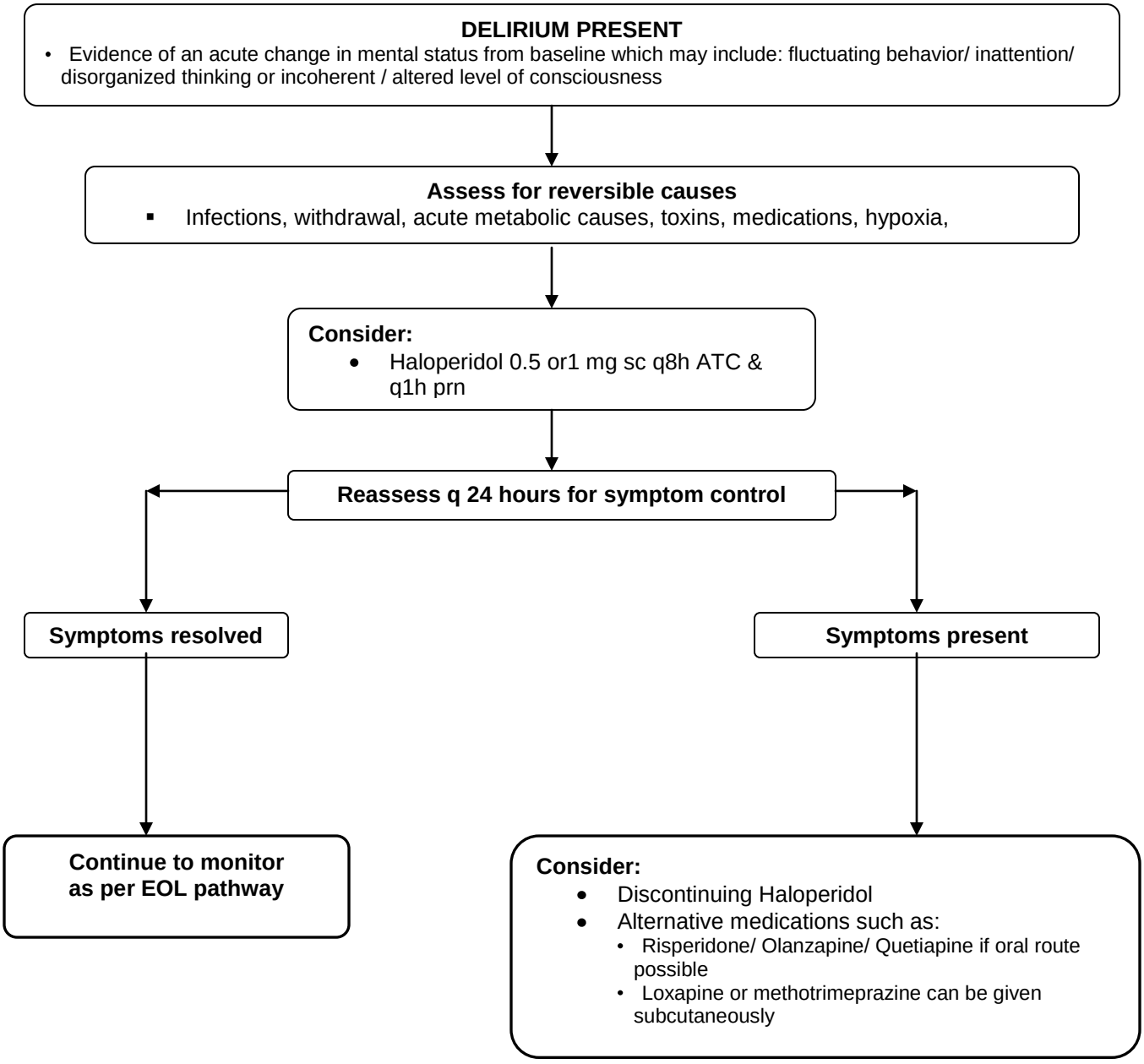
- If renal impairment present, Hydromorphone less likely to cause accumulation of metabolites, leading to opioid toxicity.
- **When initiating an opioid, consider Metoclopramide 10 mg sc q4h ATC and q1h prn AND monitor for constipation**
- **Determine if hydration is required to prevent opioid toxicity**
- **Monitor for opioid toxicity:**
- **Signs of opioid toxicity include confusion, restless, agitation, myoclonus (muscle jerks) which can progress to seizures hallucinations, and hyperalgisea (misinterpretation of pain)**

If present, consult Physician/NP/Palliative Care/Pharmacy

- **Subcutaneous dosing of opioid is equivalent to half of oral dosing**
- **If pain symptoms persist, contact Physician/NP/Palliative Care Program**
- **To convert from other strong opioids, contact Physician/NP/Palliative Care Program**
- **For further information refer to Palliative Care Tips Issues #8 at http://palliative.org**

Medication for End Of Life Symptom Management

RESOURCE GUIDE B: Delirium

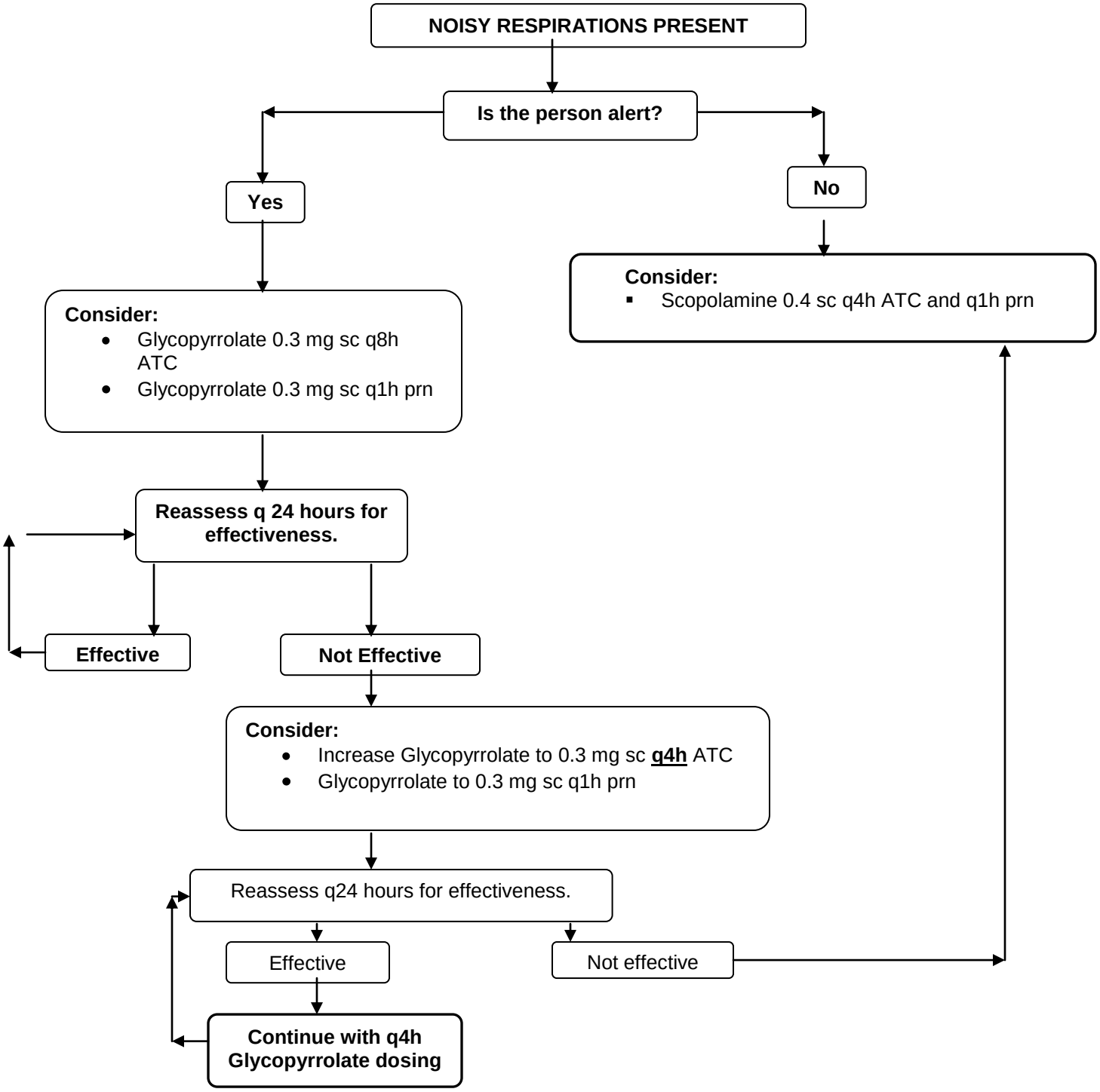


NOTE

- **If delirium symptoms persist, contact Physician /NP/ Palliative Care Program**
- **For further information refer to Palliative Care Tips Issue #1 at http://www. palliative.org**
- **Review Delirium Protocol, as available and appropriate**

Medication for End Of Life Symptom Management

RESOURCE GUIDE C: Noisy Respirations ('Death Rattle')

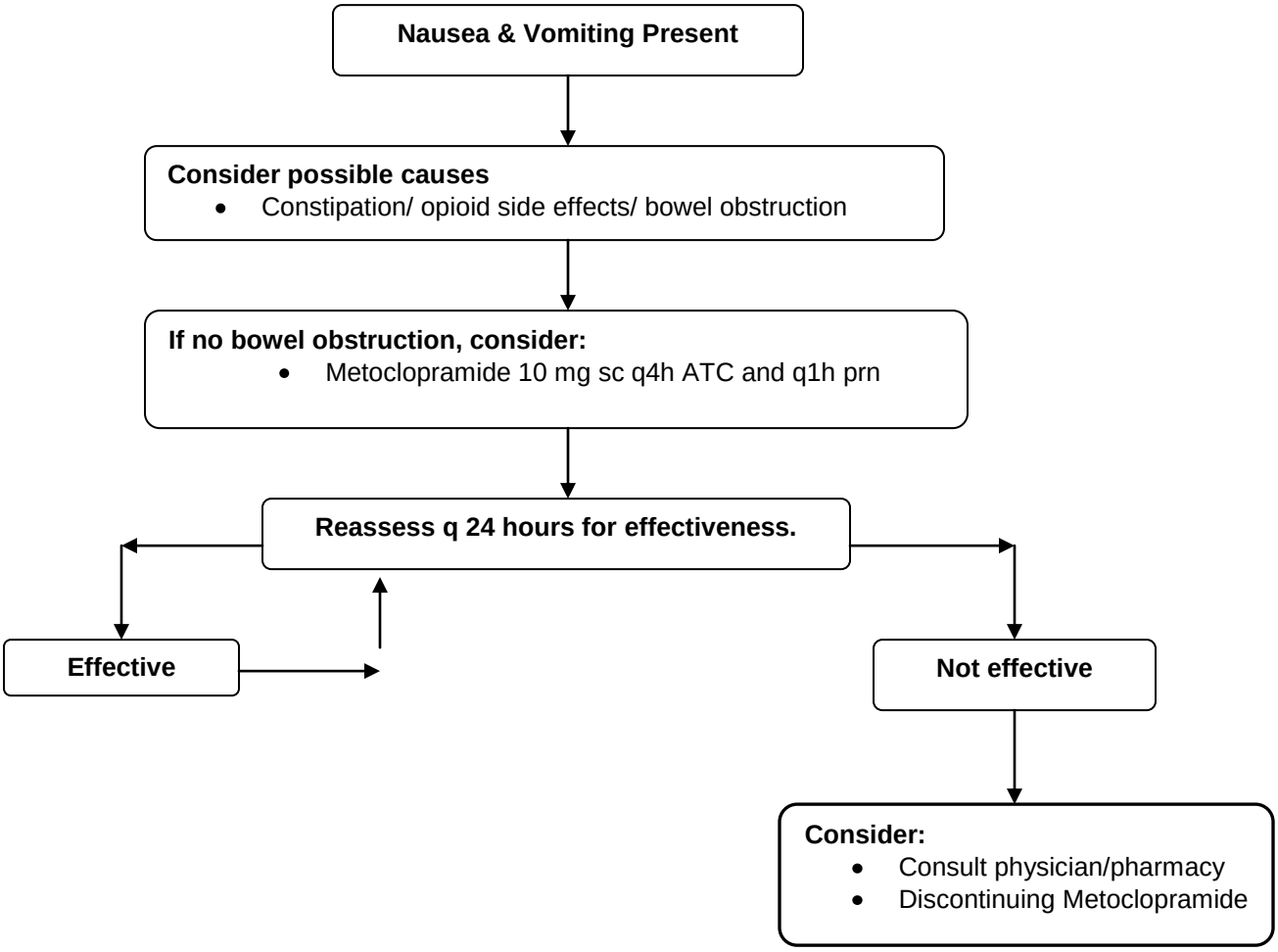


NOTE:

- **Evaluate whether hydration is contributing to respiratory secretions: consider decreasing clysis if applicable**
- **If symptoms persist contact Physician/ NP/Palliative Care Program**
- **For further information: Refer to Palliative Care Tips Issue #19 at http://www.pallative.org**

Medication for End Of Life Symptom Management

RESOURCE GUIDE D: Nausea and Vomiting

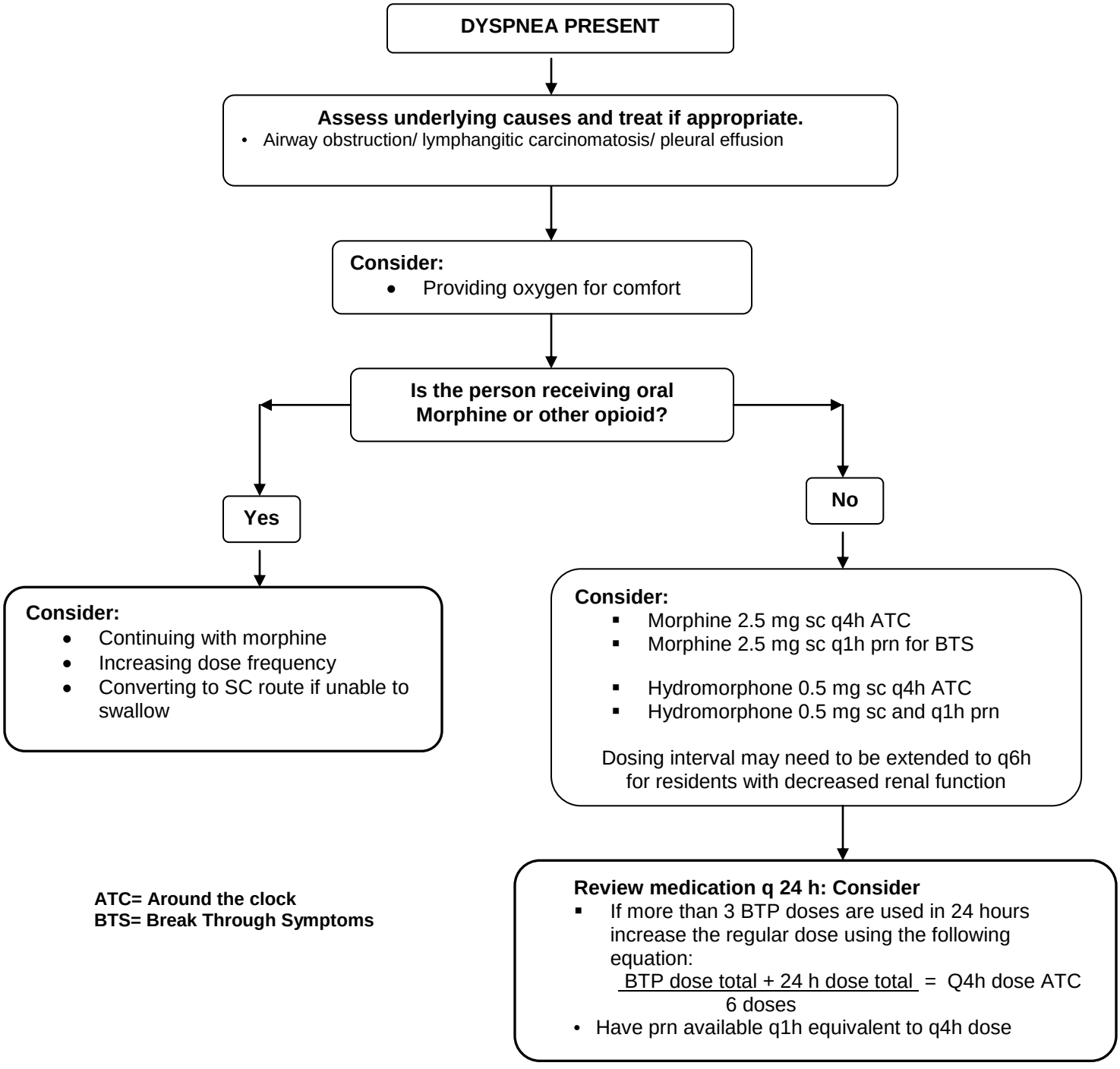


NOTE:

- **When initiating an opioid, consider Metoclopramide 10 mg sc q4h ATC and q1h prn AND monitor for constipation.**
- **If symptoms persist contact Physician/NP/ Palliative Care Program**
- **For further information, refer to Palliative Care Tips Issue # 5 at http://www.palliative.org**

Medication for End Of Life Symptom Management

RESOURCE GUIDE E: Dyspnea



ATC= Around the clock
BTS= Break Through Symptoms

NOTE:

- **When initiating an opioid, consider Metoclopramide 10 mg sc q4h ATC and q1h prn AND monitor for constipation.**
- **If symptoms persist contact Physician /NP/ Palliative Care Program**
- **For further information, refer to Palliative Care Tips Issue # 4 Dyspnea at http://www.palliative.org**

Medication for End Of Life Symptom Management
Suggested Medications and PRN Medications

Anticipatory prescribing will ensure that in the last hours/days of life there is no delay in responding to a symptom if it occurs.

Suggested Medication	Dose/Route	Symptom
Morphine	2.5 mg sc q4h **ATC**	Pain
	2.5 mg sc q1h **prn**	Breakthrough pain
Hydromorphone	0.5 mg sc q4h **ATC**	Pain (with renal function impairment)
	0.5 mg sc q1h **prn**	Breakthrough pain (with renal function impairment)
Metoclopramide	10 mg sc q1h **prn**	Nausea and Vomiting
Haloperidol	0.5 sc q8h **ATC** *or* 1 mg sc q8h **ATC**	Symptoms of Delirium
	0.5 sc q1h **prn** *or* 1 mg sc q1h **prn**	Symptoms of Delirium
Glycopyrrolate	0.3 mg sc q8h **ATC**	Noisy Respirations (in an alert resident)
	0.3 mg sc q4h **ATC** (if q8h effective)	
	0.3 mg sc q1h **prn**	Noisy Respirations (in an alert resident)
Scopolamine	0.4 mg sc q4h **ATC**	Noisy Respirations (in a resident with decreased LOC)
	0.4 mg sc q1h **prn**	Noisy Respirations (in a resident with decreased LOC)

LOC: Level of consciousness

NOTE: Consider Hydromorphone if renal function is impaired as there is less chance of metabolites accumulating, leading to opioid toxicity. For residents/patients with severely impaired renal function the dosing interval may be extended to q6h ATC.

REFERENCES

RESOURCE GUIDE A: Pain

References:

1. Lasheen W. (2008) Kidney and liver disease. In: Walsh D, et al (Eds) Palliative Medicine. Saunders Elsevier, 700-706.
2. Hardy, J. & Nauck, F. (2009) Opioids for cancer pain. In: Declan Walsh, T., Fainsinger, R., et al, Palliative Medicine. Philadelphia, PA: Saunders Elsevier, 1404-1411.
3. Pereira, J. L, Associates (2008). Pain in The Pallium palliative pocketbook: 1st Canadian Ed., Edmonton, AB: The Pallium Project, 5-1-5-92.

RESOURCE GUIDE B: Delirium

References:

1. Lawlor P, Gagnon B, Falconer W. (2005) Cognitive impairment. In: MacDonald N, Oneschuk D, Hagen N, Doyle D (Eds) Palliative Medicine, A Case-based Manual. Oxford University Press, 295-307
2. Gagnon, P. & Ouellette, M. (2009) Delirium and psychosis. In: Declan Walsh, T., Fainsinger, R., et al, Palliative Medicine. Philadelphia, PA: Saunders Elsevier, 860-865
3. Pereira, J. L, Associates (2008). Delirium in The Pallium Palliative Pocketbook: 1st Canadian Ed., Edmonton, AB: The Pallium Project, 7-1-7-16.

RESOURCE GUIDE C: Noisy Respirations ('Death Rattle')

References:

1. Muller-Busch & Jehser, T.. (2009) Death rattle. In: Declan Walsh, T., Fainsinger, R., et al, Palliative Medicine. Philadelphia, PA: Saunders Elsevier, 956-960
2. Pereira, J. L, Associates (2008). Terminal respiratory congestion ("death rattle") The Pallium palliative pocketbook: 1st Canadian Ed., Edmonton, AB: The Pallium Project, 6-23-6-25.

RESOURCE GUIDE D: Nausea and Vomiting

References:

1. De Kock, I. (2005) Nausea and vomiting. In: MacDonald N, Oneschuk D, Hagen N, Doyle D (Eds) Palliative Medicine, A Case-based Manual. Oxford University Press, 187-200
2. Abraham, J. & Fowler, B.. (2009) Nausea, vomiting and early satiety. In: Declan Walsh, T., Fainsinger, R., et al, Palliative Medicine. Philadelphia, PA: Saunders Elsevier, 921-931.
3. Pereira, J. L, Associates (2008). Nausea and vomiting in The Pallium palliative pocketbook: 1st Canadian Ed., Edmonton, AB: The Pallium Project, 8-1-8-13.

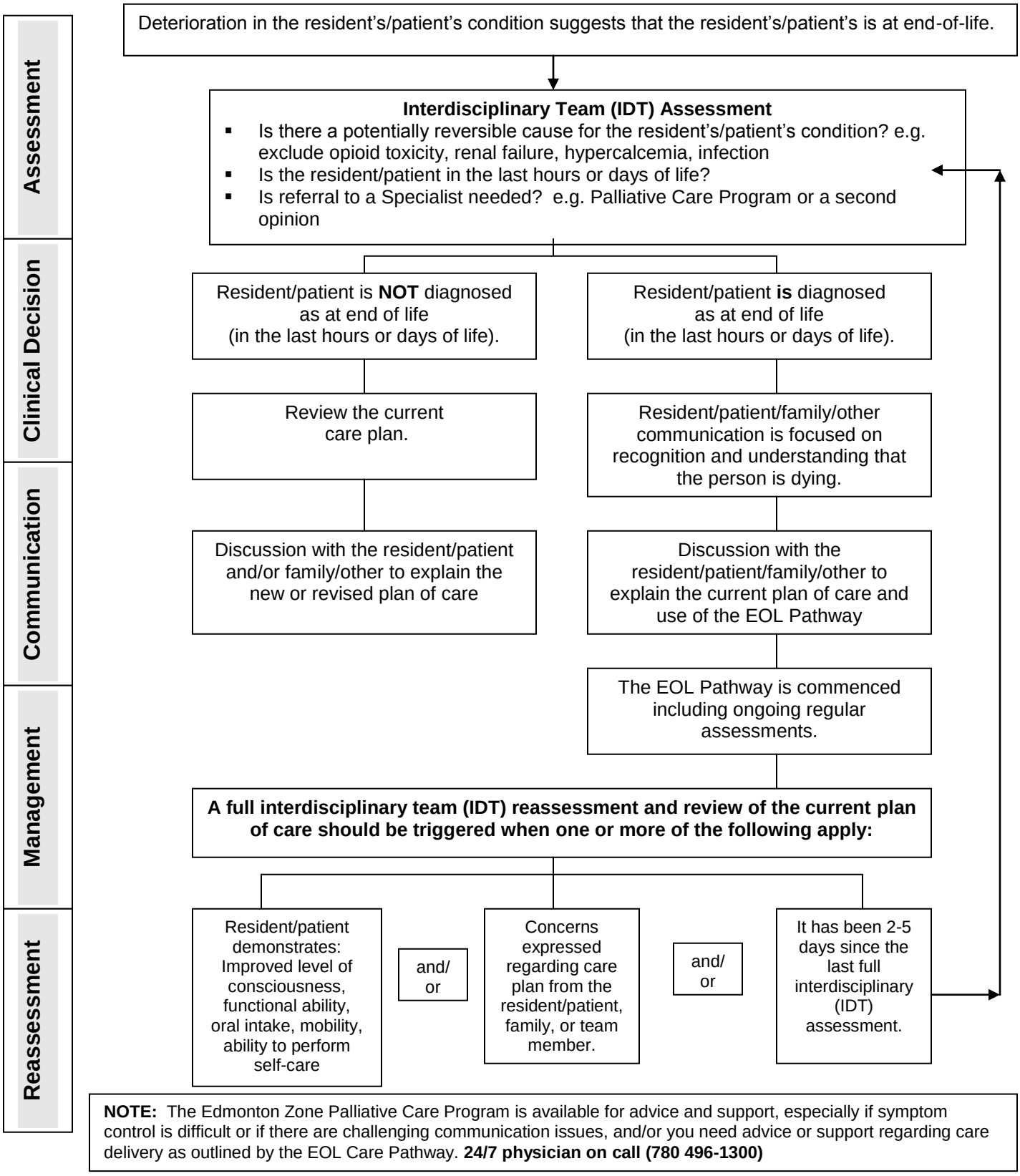
RESOURCE GUIDE E: Dyspnea

References:

1. Shad, J. & Dudgeon, D. (2009) Dyspnea. In: Declan Walsh, T., Fainsinger, R., et al, Palliative Medicine. Philadelphia, PA: Saunders Elsevier, 877-881.
2. Pereira, J. L, Associates (2008). Shortness of breath (dyspnea) The Pallium palliative pocketbook: 1st Canadian Ed., Edmonton, AB: The Pallium Project, 6-1-6-17.

APPENDIX 1

Palliative Care Pathway
Implementation/Reassessment Algorithm



NOTE: The Edmonton Zone Palliative Care Program is available for advice and support, especially if symptom control is difficult or if there are challenging communication issues, and/or you need advice or support regarding care delivery as outlined by the EOL Care Pathway. **24/7 physician on call (780 496-1300)**

APPENDIX 2

Spiritual Rites and Rituals Assessment Form at End of Life

Spiritual/Cultural Protocols

Identify Spiritual/Cultural Rites and Rituals requested prior to death:

□ Requested positioning of body:
_____

□ Requested use of touch:
_____

□ Requirements for cleaning of body:
_____

□ Requirements for dressing/covering of body:
_____

□ Other
_____

Identify Spiritual/Cultural Rites and Rituals requested immediately following death:

□ Requested positioning of body:
_____

□ Requested use of touch:
_____

□ Requirements for cleaning of body:
_____

□ Requirements for dressing/covering of body:
_____

□ Other
_____

□ If available, may body be removed to the facility morgue?
□ Yes □ No

Source of Request:
□ Resident/patient cognitively intact □yes □ no
□ Spouse/Partner/Agent
□ Family _____ (name)
□ Other: e.g. Friend_____ (name)

Signature & designation of person assessing:

_____ Date: _____

Consultants: CAPPE Hospice and Spiritual Care Providers
National CAPPE Professional Practice Commission
GNCH Department of Spiritual Care
Adapted (with permission)