MINISTRY OF HEALTH
MANATŪ HAUORA

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

PATIENT ID LABEL

BINDING MARGIN – NO WRITING

Te Ara Whakapiri – the path of closeness and unity
Information for Healthcare Professionals regarding the Last Days of Life

RECOGNISING DYING CAN BE COMPLEX

- Utilise the algorithm over the page to support your multidisciplinary team (MDT) assessment.

COMMUNICATE, INVOLVE AND SUPPORT

Sensitive, comprehensive, clear communication is required between all parties.

- Communicate the possibility the person may die in the next few hours or days to the person (if able and appropriate), to those important to them (e.g. EPA or NOK, whānau – extended family, family group) and the MDT.
- Shared decisions are made about treatment and care in consideration of the wishes, wants and/or needs of the dying person, as able.
- 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 whānau and those important to them to be informed about their condition and prognosis.
- Communication must be conducted in a way that maximizes privacy, sensitivity, compassion and is culturally appropriate.
- The needs of the person are actively explored, respected and met as far as possible, in partnership with whānau.
- Staff must check and document the person's understanding (and others who have been involved) of the information that is being communicated.

CREATE AN INDIVIDUALISED CARE PLAN

- The care plan is based on the principles of Te Ara Whakapiri and includes the provision of food and fluids (as able), symptom control and physical, psychosocial, cultural and spiritual support.
- Care is agreed, co-ordinated and delivered with dignity, care and compassion.
- The care plan utilises clinical evidence and clinical judgement.
- Symptom management guidelines are provided at the end of the document for the most common symptoms at the end of life.
- The care plan is generic for use in all health care settings; therefore each organisation should provide staff with education and further guidance as to their organisations specific requirements (e.g. electronic records, responsibilities, and contact processes).

REVIEW

- The care plan is dynamic and is **reviewed at least daily.**
- The person's condition, needs and wishes are responded to appropriately.
- Medications, their appropriateness and use, is reviewed and non-essential medication discontinued.
- The focus of medications is on those that are beneficial at this time to manage current symptoms and symptoms that commonly occur at the end of life such as pain, respiratory tract secretions, restlessness and agitation, breathlessness, nausea and vomiting.
- Utilise the algorithm over the page for triggers for a full MDT assessment.
- If the person's condition stabilises/improves and is assessed as no longer dying, this care plan should be stopped and a new care plan developed.

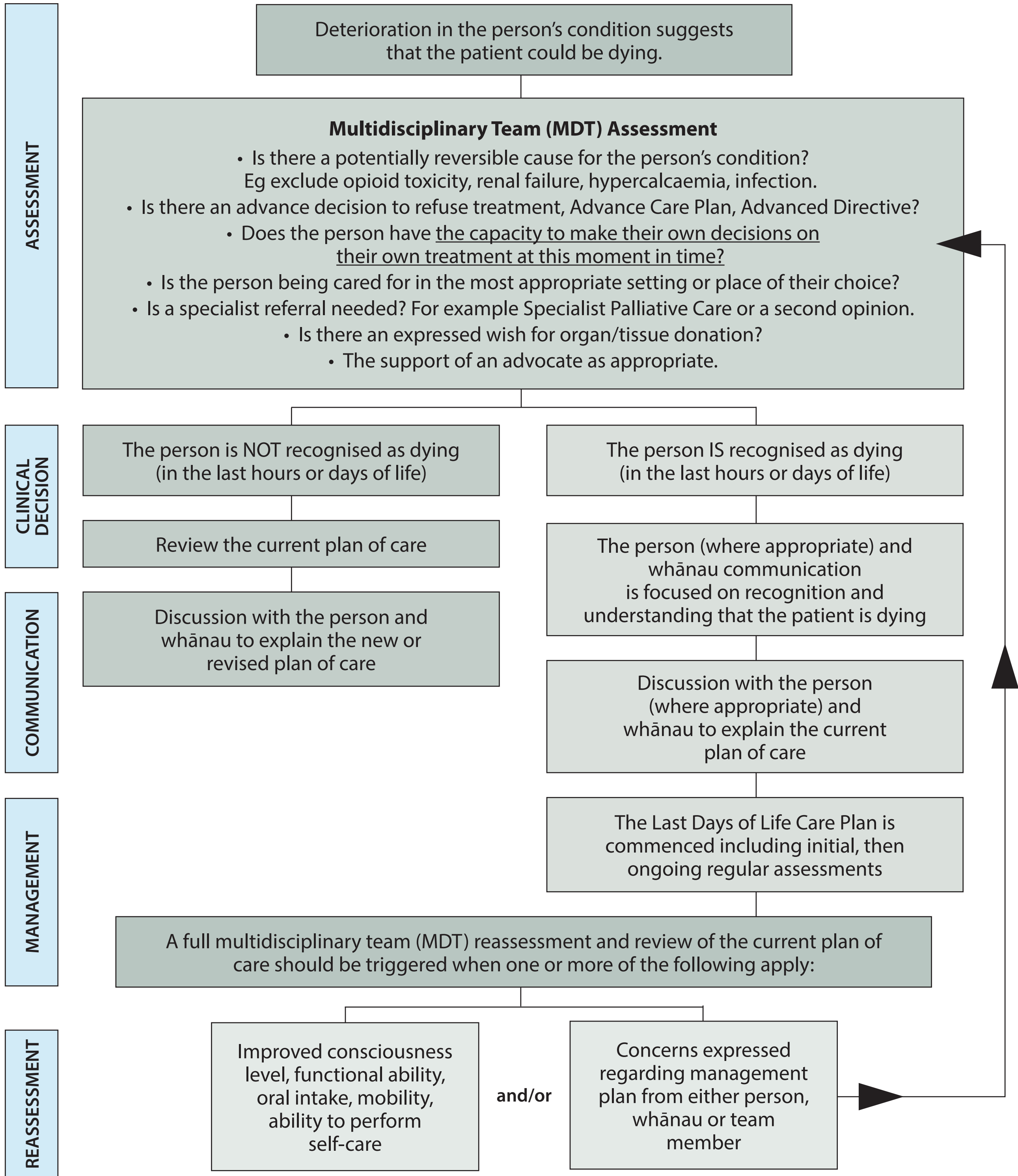
MINISTRY OF HEALTH
MANATŪ HAUORA

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

PATIENT ID LABEL

ALGORITHM

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



BINDING MARGIN – NO WRITING

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 •

MINISTRY OF HEALTH
MANATŪ HAUORA

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

PATIENT ID LABEL

Te Ara Whakapiri – Care in the Last Days of Life

Initial assessment

Recognition that the person is dying or is approaching the last days of life:

Is the ***Recognising the Dying Person Flow Chart*** available to support decision making? ☐ Yes

Diagnosis ....

Lead practitioner's name: .... Designation: ....

Lead practitioner's contact no (Community): .... After-hours contact no (Community): ....

Note: The lead practitioner is the person's GP, nurse practitioner or hospital specialist.

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

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

Date care plan discontinued: .... **Time care plan discontinued:** ....

Reasons why the care plan was discontinued by the MDT: ....

....

Person's awareness of their changing condition:

Is the person aware they may be entering the last few days of life? ☐ Yes ☐ No

Whānau awareness of the person's changing condition:

A conversation and shared discussion between the health professional, the person, and whānau has occurred and they are aware that the person may be entering the last hours or few days of life? ☐ Yes ☐ No

Summary ....

....

....

....

OR refer to: ☐ Clinical notes ☐ Shared goals of care

If No, record reasons ....

....

....

Whānau contact:

If the person's condition changes, who should be contacted first? Name ....

Relationship to person .... Phone (H) .... (Mob) ....

Best time to contact: ☐ At any time ☐ Not at night-time ☐ Staying overnight

Is an Enduring Power of Attorney in place? ☐ Yes ☐ No

Has it been activated? ☐ Yes ☐ No ☐ N/A

Advice to relevant agencies of the person's deterioration:

Has the GP practice been contacted and informed the person is dying?
(if out of hours, contact next working day) ☐ Yes ☐ No ☐ N/A

Is there anyone else that the person/whānau wants notified? ☐ Yes ☐ No ☐ N/A

Details ....

....

....

BINDING MARGIN – NO WRITING

MINISTRY OF HEALTH
MANATŪ HAUORA

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

PATIENT ID LABEL

BINDING MARGIN – NO WRITING

Doctor or nurse practitioner to complete this section

Provision of food and fluids:

A conversation has occurred regarding the nutritional and hydration needs of the person.

Summary ....

....

....

Is clinically assisted (artificial) nutrition and/or hydration in place? ☐ Yes ☐ No

If yes, record route: ☐ Subcut ☐ IV ☐ NG/NJ ☐ PEG/PEJ ☐ TPN

Ongoing clinically assisted (artificial) nutrition is:

☐ Not required ☐ Discontinued ☐ Continued ☐ Commenced

Ongoing clinically assisted (artificial) hydration is:

☐ Not required ☐ Discontinued ☐ Continued ☐ Commenced

Review of current management and prescribing of anticipatory medication:

Has current medication been assessed and non-essentials discontinued? ☐ Yes

Has the person's need for current interventions been reviewed? ☐ Yes

Anticipatory prescribing of medication to ensure there is no delay in responding to symptoms completed (refer to relevant symptom management algorithms):

Pain: ☐ Yes

Agitation: ☐ Yes

Respiratory tract secretions: ☐ Yes

Nausea/vomiting: ☐ Yes

Dyspnoea/breathlessness: ☐ Yes

Does the person have a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order? ☐ Yes ☐ No

Has the conversation occurred with the person/whānau about the changing Goals of Care and this care plan? ☐ Yes ☐ No

Summary ....

....

Consideration of cardiac devices:

Does the person have a cardiac device (e.g. cardioverter defibrillator (ICD) or ventricular assist device)? ☐ Yes ☐ No

Has the conversation occurred with the person/whānau
about deactivation of the device and consequences of this decision? ☐ Yes ☐ No

Has the cardiac device been deactivated? ☐ Yes ☐ No

Full documentation in the clinical record is required for any issues identified.

This review has been discussed with the person where possible and appropriate, and with the appropriate support person(s) (e.g. EPA, or whānau), including plan of care, additional treatment/interventions and/or care-related issues (e.g. food, fluids, place of care, level of care, cardiopulmonary resuscitation).

Summary ....

....

....

Doctor/Nurse Practitioner name (print) ....

Signature .... Date .... Time ....

MINISTRY OF HEALTH
MANATŪ HAUORA

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

PATIENT ID LABEL

Te taha tinana – *Physical health*

Assessment of physical needs:

Is the person: ☐ Conscious ☐ Semi-conscious ☐ Unconscious

In pain:	☐ Yes	☐ No	Able to swallow:	☐ Yes	☐ No	Confused:	☐ Yes	☐ No
Agitated:	☐ Yes	☐ No	Continent (bladder):	☐ Yes	☐ No	Respiratory tract secretions:	☐ Yes	☐ No
Nauseated:	☐ Yes	☐ No	Catheterised:	☐ Yes	☐ No			
Vomiting:	☐ Yes	☐ No	Continent (bowels):	☐ Yes	☐ No	Skin integrity at risk:	☐ Yes	☐ No
Dyspnoeic:	☐ Yes	☐ No	Constipated:	☐ Yes	☐ No	At risk of falling:	☐ Yes	☐ No

Is the person experiencing other symptoms (e.g. oedema, myoclonic jerks, itching)? ☐ Yes ☐ No

Describe and record on page 7 ....

....

Availability of equipment:

Is the necessary equipment available to support the person's care needs
(e.g. air mattress, hospital bed, syringe driver, pressure-relieving equipment)? ☐ Yes ☐ N/A ☐ Needs action

Te taha hinengaro – *Psychological and mental health*

Assessment of the person's preferences and wishes for care

Does the person have an advance care plan (ACP)/or other directive?

☐ Yes ☐ No ☐ Sighted *(include wishes from ACP/or other directive in this plan)*

Has the person expressed a preferred place of care? ☐ No preference ☐ Home ☐ ARC ☐ Hospital ☐ Hospice

Does the person have any cultural preferences? ☐ Yes ☐ No

If yes, describe ....

Does the person have any emotional or psychological symptoms or concerns? ☐ Yes ☐ No

If yes, describe ....

Te taha wairua – *Spiritual health*

Ascertain from the person (if possible), feelings, spiritual beliefs, religious traditions and/or values that are important to them at this time *(refer to the person's ACP/He Waka Kakarauri for personal wishes if completed)*: ☐ Yes ☐ Not able

Specify ....

....

Ascertain from whānau, feelings, beliefs, religious tradition &/or values that are important to the person at this time. ☐ Yes ☐ Not able

Specify if applicable, including any identified religious traditions:

....

....

Has the person's own spiritual advisor/minister/priest been contacted? ☐ Yes ☐ N/A

Name .... Contact no .... Date/time ....

Are there other needs to address (e.g. access to the outdoors, pets, touch therapy, music, prayer, literature, etc.)? ☐ Yes ☐ No

If yes, describe ....

Te whānau – *Extended family health*

Identification of communication barriers and discussion of needs

Is the person able to take a full and active part in communication? *(Seek interpreter/communication aids if needed)*: ☐ Yes ☐ No

Have the cultural needs of whānau been identified and documented? ☐ Yes ☐ No

Has the person and/or whānau expressed concern about previous experiences of death and dying? ☐ Yes ☐ No

If yes, please document ....

BINDING MARGIN – NO WRITING

MINISTRY OF HEALTH
MANATŪ HAUORA

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

PATIENT ID LABEL

BINDING MARGIN – NO WRITING

Te whānau – *Extended family health (continued)*

Provision of information to whānau about support and facilities:

Has whānau received information about support and facilities available to them? ☐ Yes ☐ No

Has the *"What to Expect When Someone is Dying"* brochure been offered to whānau? ☐ Yes ☐ No

If the person is being cared for at home, has whānau received information about who to contact after hours if the person's condition changes? ☐ Yes ☐ N/A

Has advice been given to whānau on what to do in an emergency? ☐ Yes ☐ N/A

Full documentation in the clinical record is required for any issues identified in this assessment.

Nurse's name (print) .... Date ....

Signature and designation .... Time ....

Preparation for death and care after death

Is the Coroner likely to be involved? ☐ Yes ☐ No

Has the whānau been given the opportunity to express spiritual/religious and cultural needs at time of death and after death? ☐ Yes ☐ No

Note: Provide an opportunity to talk with whānau about their spiritual, religious or cultural needs

....

....

Is the person for: ☐ Burial ☐ Cremation

Funeral Director ....

Has a private space been made available for whānau? ☐ Yes ☐ No

Note: Respect whānau need for privacy, ensure a private space is available for prayer, karakia or other cultural or spiritual needs.

Time of death: .... Date of death: ....

The person's lead practitioner & usual multi-disciplinary team informed of person's death: ☐ Yes ☐ No ....

The appropriate services across the organisation notified of person's death: ☐ Yes ☐ No ....

Date and time death verified: ....

A Death Certificate been completed: ☐ Yes ☐ No ☐ N/A *(e.g. if the death is referred to the coroner)*

A Cremation Certificate has been completed: ☐ Yes ☐ No ☐ N/A

Documents have been completed: ☐ Online or ☐ Hardcopy

Tupāpakū (deceased person) is treated with dignity and respect. Ensure the wishes and cultural requirements of the deceased person and their whānau are met in terms of after-death care.

Note: Support whānau to participate in after-death care if they wish to be involved, undertake after-death care according to local policies and procedures, including those applying to the return personal belongings to whānau in a respectful way.

Whānau is provided with information about what to do next.

Has a conversation been held with the whānau to ensure they have adequate information about what to do next? ☐ Yes ☐ No

Has written material been offered *(may include information regarding local funeral directors, funeral planning etc)*? ☐ Yes ☐ No

Whānau is able to access information about bereavement support and counselling if needed? ☐ Yes ☐ No

Has written material been offered? This may include the brochure *"What to expect when someone is grieving"*. ☐ Yes ☐ No

Consider arrangements for blessing the room/bed space.

Nurse's name (print):	**Signature and designation:**

MINISTRY OF HEALTH
MANATŪ HAUORA

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

PATIENT ID LABEL

Ongoing Care of the Dying Person

Use the ACE coding below, initial each entry and record details in the progress notes. Seek a second opinion or specialist palliative care support as needed.

A C E codes:	A = Achieved No additional intervention required	C = Change Intervention required and documented	E = Escalate Medical, NP or senior nurse review required and documented

Domains and goals	Date: / /						Date: / /					
	Time: 0400	0800	1200	1600	2000	2400	0400	0800	1200	1600	2000	2400
Te taha tinana – *Physical health*												
Pain The person is pain free at rest and during any movement.												
Agitation/delirium/restlessness The person is not agitated or restless and does not display signs of agitated delirium or terminal anguish.												
Respiratory tract secretions The person is not troubled by excessive secretions.												
Nausea The person is not nauseated.												
Vomiting The person is not vomiting.												
Breathlessness/dyspnoea The person is not distressed by their breathing.												
Mouth care The person's mouth is moist and clean.												
Additional symptom 1 *(as identified on pg 5)* *For example, the person is free of other distressing symptoms (like myoclonic jerks, itching).*												
Additional symptom 2 *(as identified on pg 5)* The person is not distressed by												
Nurse initials each set of entries												

	AM	PM	Nocte	AM	PM	Nocte
Elimination (bowels and urination) Outputs are managed with pads, catheters, stoma care, rectal interventions etc. *Note: Observe for distress due to any of the following: constipation, faecal impaction, diarrhoea, urinary retention.*						
Mobility/pressure injury prevention The person is in a safe and comfortable environment. Repositioning and use of pressure relieving equipment is effective.						

BINDING MARGIN – NO WRITING

MINISTRY OF HEALTH
MANATŪ HAUORA

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

PATIENT ID LABEL

A C E codes:	A = Achieved No additional intervention required	C = Change Intervention required and documented	E = Escalate Medical, NP or senior nurse review required and documented

Domains and goals	Date:	/ /			/ /		
	Time:	AM	PM	NOCTE	AM	PM	NOCTE
Te taha tinana – *Physical health*							
Hygiene/skin care The person's personal hygiene needs are met. The person's whānau has been given the opportunity to assist with the person's personal care.							
Food/fluids Oral intake is maintained for as long as the person wishes. If in place, artificial hydration and feeding is meeting the person's needs.							
Te taha hinengaro – *Psychological/mental health*							
Emotional support Any emotional distress such as anxiety is acknowledged and support is provided.							
Cultural The person's cultural needs are acknowledged and respected.							
Other psychological or cultural needs are being met *(as identified on pg 5)*							
Te taha wairua – *Spiritual health*							
Addressing spiritual needs Religious and spiritual support is offered to the person and to their whānau as per the person's wishes.							
Other spiritual needs are being met *(as identified on pg 5)*							
Te taha whānau – *Extended family health* *(these items refer to the health of the carers, not the person)*							
Emotional support Any distress relating to issues such as grief and anxiety is acknowledged and addressed. The need for privacy is respected.							
Practical support Advice and guidance are offered according to the needs of the person's whānau.							
Cultural support The cultural needs of whānau are reviewed and care is mindful of these needs.							
Communication Communication is open to address any fears or concerns about the dying process.							
Nurse initials each set of entries							

BINDING MARGIN – NO WRITING

MINISTRY OF HEALTH
MANATŪ HAUORA

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

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.

BINDING MARGIN – NO WRITING

MINISTRY OF HEALTH
MANATŪ HAUORA

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

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.

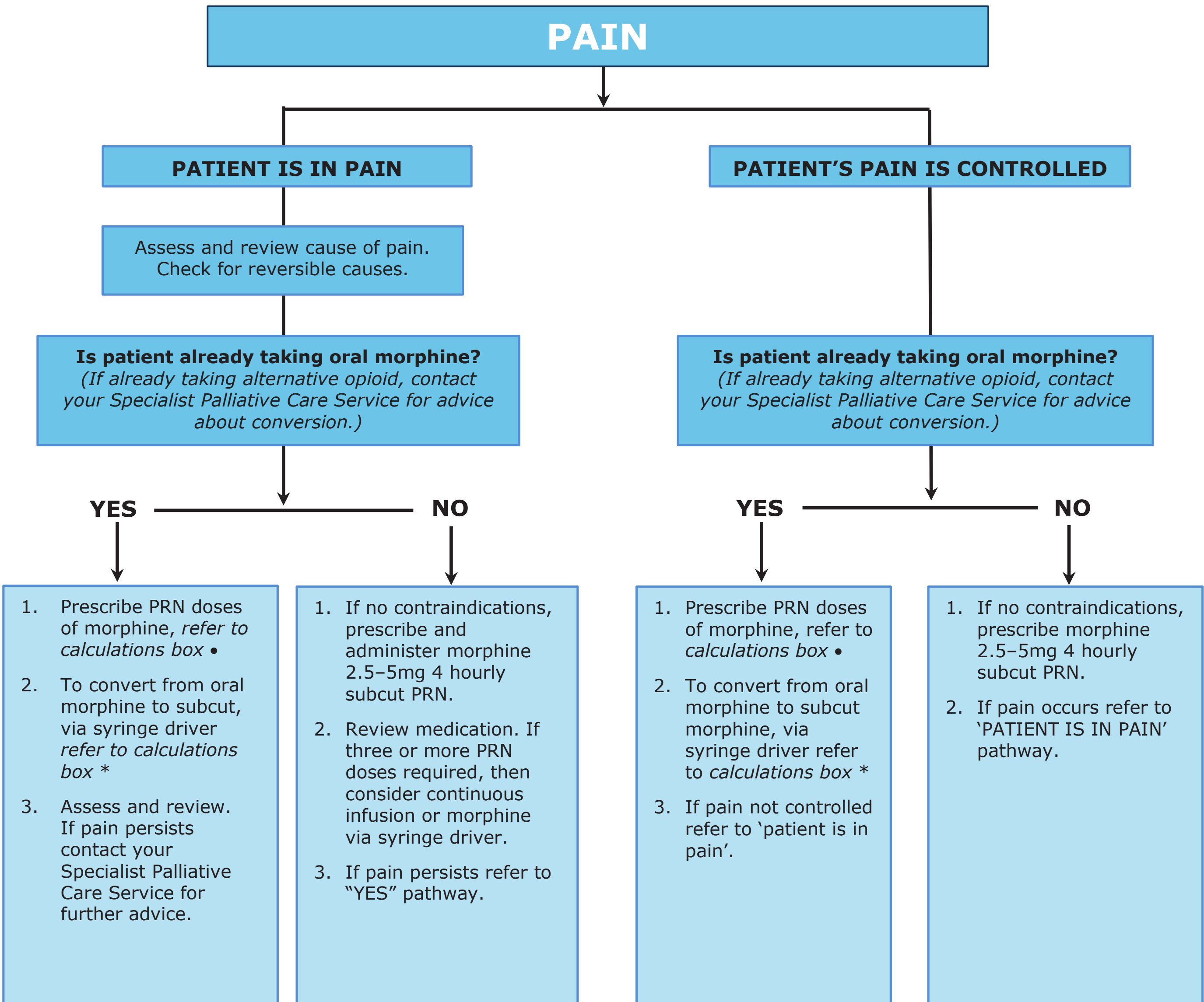
BINDING MARGIN – NO WRITING

MINISTRY OF HEALTH
MANATŪ HAUORA

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

PATIENT ID LABEL

BINDING MARGIN – NO WRITING



Supporting Information:

- To convert from alternative opioid contact Specialist Palliative Care services for advice.
- Review drug, dose and frequency for patients who are elderly, frail, have dementia or renal failure. Start with lower doses and increase slowly as required.
- If pain is INCIDENT pain only (e.g. on turning) continue with long acting doses and utilise PRN pre-emptive doses.

NB:
subcut (subcutaneous)
PRN (as required)

Calculations

Morphine/Oxycodone:

To CONVERT from oral morphine to subcutaneous morphine: subcutaneous dose = 1/2 oral dose.
To CONVERT from oral oxycodone to subcutaneous oxycodone: subcutaneous dose = 2/3 oral dose.
To CONVERT to 24 hr *continuous subcutaneous infusion (CSCI): Contact your specialist palliative care service for advice.
TO CALCULATE PRN subcutaneous or oral doses (morphine or oxycodone): PRN dose = 1/6 total 24 hour dose 3-4 hourly.

NB: If you require further advice at any time, 24 hours a day, please contact Arohanui Hospice (06) 356 6606.
For Palmerston North Hospital inpatients contact the Hospital Palliative Care Service, Mon to Fri, 8.30am – 5pm.

MINISTRY OF HEALTH
MANATŪ HAUORA

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

PATIENT ID LABEL

For those with Renal Impairment (eGFR≤30) or (eGFR≤15)
PAIN (see Practice Point below)

Is patient already taking oral opioids?
Is the patient already taking opioids?
(If eGFR <30 but >15 consider oxycodone).

YES

See Practice Point below:
1. If patient is already taking strong opioids, keep dosing orally for as long as possible.
2. Prescribe PRN doses of opioid
   - 2.1 For those established on oxycodone consider 1–3mg 4 hourly subcut PRN
   - 2.2 For severe renal failure and those established on Fentanyl consider 12.5–25 micrograms subcut 1–2 hourly PRN.
3. To convert to subcut via syringe driver refer to "CALCULATIONS" box on previous page.
4. Contact your Specialist Palliative Care Service for advice for converting methadone to subcut dosing.

NO

1. eGFR 15-30: oxycodone 1–3mg 4 hourly subcut PRN.
2. eGFR ≤15: fentanyl 25 micrograms subcut 1–2 hourly PRN.

NB:
subcut (subcutaneous)
PRN (as required)

If three or more doses are required over 24 hours consider starting a syringe driver of oxycodone or fentanyl.

Example for oxycodone:

10mg oxycodone in a syringe driver over 24 hours, PRN dose should be 1/6th of the 24 hour dose.
PRN dosing; 10mg oxycodone give 1–3mg 3–4 hourly.

Example for Fentanyl:

Fentanyl 100–250 micrograms in a syringe driver over 24 hours, PRN dose should be 1/8th of the 24 hour dose.
PRN dosing; 100 micrograms/24 hours give 12.5 micrograms 1–2 hourly PRN.
PRN dosing; 200 micrograms/24 hours give 25 micrograms 1–2 hourly PRN.

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.
- **When discharging to community from hospital and the person is using fentanyl ensure this is available in community setting.**

Calculations

Fentanyl:
For patient established on transdermal fentanyl the subcutaneous PRN dose is roughly equivalent to the hourly transdermal dose, to a maximum of 100 micrograms (2mls) e.g. 25 micrograms subcutaneously PRN 1 hourly. If hourly PRN dosing is not practical in the community then alternatively oxycodone can be used 4 hourly. For dosing advice call specialist palliative care services.

Practice Point: **"Because of the risk associated with using an unfamiliar opioid, a pragmatic approach is important. Thus, the cautious use of a familiar opioid (including morphine) may be preferable to switching to an unfamiliar (albeit safer) one. The ease of obtaining and, administering and titrating the opioid are also important considerations, particularly in the community setting".**
Palliative Care Formulary, 7th Edition p727.

NB: If you require further advice at any time, 24 hours a day, please contact Arohanui Hospice (06) 356 6606.
For Palmerston North Hospital inpatients contact the Hospital Palliative Care Service, Mon to Fri, 8.30am – 5pm.

BINDING MARGIN – NO WRITING

MINISTRY OF HEALTH
MANATŪ HAUORA

MIDCENTRAL DISTRICT HEALTH BOARD
Te Pae Hauora o Ruahine o Tararua

PATIENT ID LABEL

Differentiate between dyspnoea and respiratory tract secretions

DYSPNOEA

PRESENT

Is patient already taking oral morphine or oxycodone for breathlessness?

YES

1. Convert to subcut morphine or oxycodone, prescribe and administer PRN 4 hourly.

NO

1. Prescribe and administer Morphine 2.5mg–5mg subcut PRN 4 hourly, for dyspnoea.

2. Assess, if still dyspnoeic, consider adjusting morphine or oxycodone dose and/or administering via syringe driver.

   If dyspnoeic **and anxious**:
   - Consider adding midazolam 2.5–5mg subcut PRN 4 hourly
   - Consider continuous infusion of midazolam 5–15mg via syringe driver (lower dose for age and frailty).

3. If dyspnoea persists contact your Specialist Palliative Care Service for further advice.

ABSENT

Is patient already taking oral morphine?

YES

Prescribe appropriate PRN morphine dose for pain or dyspnoea.

NO

Prescribe morphine 2.5–5mg subcut PRN 4 hourly for dyspnoea.

NB:
subcut (subcutaneous)
PRN (as required)

BINDING MARGIN – NO WRITING

Supporting Information:

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

Calculations

Morphine/Oxycodone:

To CONVERT from oral morphine to subcutaneous morphine: subcutaneous dose = 1/2 oral dose.
To CONVERT from oral oxycodone to subcutaneous oxycodone: subcutaneous dose = 2/3 oral dose.
To CONVERT to 24 hr *continuous subcutaneous infusion (CSCI): Contact your specialist palliative care service for advice.
TO CALCULATE PRN subcutaneous or oral doses (morphine or oxycodone): prn dose = 1/6 total 24 hour dose 3–4 hourly.

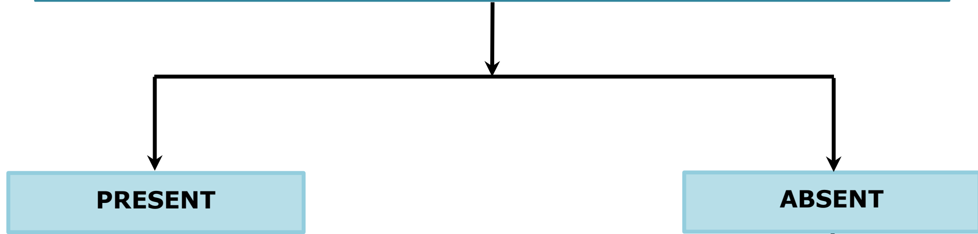
NB: If you require further advice at any time, 24 hours a day, please contact Arohanui Hospice (06) 356 6606.
For Palmerston North Hospital inpatients contact the Hospital Palliative Care Service, Mon to Fri, 8.30am – 5pm.

MINISTRY OF HEALTH
MANATŪ HAUORA

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

PATIENT ID LABEL

TERMINAL RESTLESSNESS & AGITATION



PRESENT

- Exclude pain
- Exclude urinary retention
- Consider spiritual distress

1. Prescribe and administer midazolam 2.5–5mg subcut PRN 4 hourly (lower dose for age and frailty).
2. Continue to give PRN doses; if 3 or more doses are required in 24 hours, go to Step 3.
3. Review and assess, consider initiating a syringe driver using the total required dose over the previous 24 hours as a guide to dosage. Continue to review daily and titrate – see "Supporting Information".
4. If restlessness and agitation persist, contact your Specialist Palliative Care Service for further advice.

ABSENT

1. Prescribe midazolam 2.5–5mg subcut PRN 4 hourly.

If restlessness and agitation occur change to symptom ***"PRESENT"*** guide.

Pre-existing conditions

- In conditions such as dementia with BPSD (Behavioural and Psychological Symptoms of Dementia), many of the routinely used medications cannot be given subcutaneously so alternatives need to be prescribed.
- For patients on large doses of background anxiolytics, higher doses of benzodiazepines may be required at the end of life.

NB:
subcut (subcutaneous)
PRN (as required)

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 and frequency for patients who are elderly, frail, have dementia or renal failure. Start with lower doses and increase slowly as required.

NB: If you require further advice at any time, 24 hours a day, please contact Arohanui Hospice (06) 356 6606.
For Palmerston North Hospital inpatients contact the Hospital Palliative Care Service, Mon to Fri, 8.30am – 5pm.

BINDING MARGIN – NO WRITING

MINISTRY OF HEALTH
MANATŪ HAUORA

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

PATIENT ID LABEL

RESPIRATORY TRACT SECRETIONS

PRESENT

- Explain symptom to family and whanau.
- Re-position patient.
- If the symptoms persist and is distressing for the patient, family or whānau, move to next step.

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

2a. Assess – if symptoms persist and stat dose of hyoscine-n-butylbromide **was** helpful.

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

2b. Assess – if symptoms persist and stat dose of hyoscine-n-butylbromide **was not** 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 hyoscine-n-butylbromide 20mg subcut PRN 4 hourly.

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

NB:
subcut (subcutaneous)
PRN (as required)
hyoscine-n-butylbromide = Buscopan
scopolamine TTS = Scopaderm

Supporting Information:

- Early use of medication may enable more successful management of this symptom.
- Review drug, dose and frequency for patients who are elderly, frail, have dementia or renal failure. Start with lower doses and increase slowly as required.
- Anti-cholinergic medication may not alleviate this symptom.

BINDING MARGIN – NO WRITING

NB: If you require further advice at any time, 24 hours a day, please contact Arohanui Hospice (06) 356 6606. For Palmerston North Hospital inpatients contact the Hospital Palliative Care Service, Mon to Fri, 8.30am – 5pm.

MINISTRY OF HEALTH
MANATŪ HAUORA

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

PATIENT ID LABEL

BINDING MARGIN – NO WRITING

NAUSEA & VOMITING

PRESENT

1. Prescribe and administer levomepromazine 2.5–5mg subcut PRN 8 hourly.
2. Consider regular administration via syringe driver if symptom persists. i.e. levomepromazine 5mg over 24 hours. Ensure a subcut PRN dose is also available.
3. Review dosage after 24 hours.
4. If symptoms persist, consider increasing dose i.e. levomepromazine 8–10mg over 24 hours via syringe driver.
5. If symptoms persist contact your Specialist Palliative Care Service for further advice.

ABSENT

1. Prescribe levomepromazine 2.5–5mg subcut 8 hourly PRN.

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

NB:
subcut (subcutaneous)
PRN (as required)

Supporting Information:

- Levomepromazine can be sedating.
- Review drug, dose and frequency for patients who are elderly, frail, have dementia or renal failure. Start with lower doses and increase slowly as required.

NB: If you require further advice at any time, 24 hours a day, please contact Arohanui Hospice (06) 356 6606.
For Palmerston North Hospital inpatients contact the Hospital Palliative Care Service, Mon to Fri, 8.30am – 5pm.