

# LIVERPOOL CARE PATHWAY (LCP)

THIS INFORMATION IS CONFIDENTIAL TO THE  
PATIENTS AND STAFF

PLEASE DO NOT READ WITHOUT THE PATIENT'S PERMISSION

**Useful contact numbers:-**

**District Nurses can be contacted as follows:**

**Monday to Friday 08.30 – 6pm on 01904 627635**

**All other times: 08450 568060**

**Preferred Place of Care .....**

Please return these notes to:

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.....  
.....  
.....

**THE INTEGRATED CARE PATHWAY FOR THE DYING PATIENT**

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

	Name	Telephone
<b>PATIENT</b>	.....	.....
<b>DATE OF BIRTH</b>	.....	
<b>NHS No.</b>	.....	
<b>NEXT OF KIN</b>	.....	.....
<b>GENERAL PRACTITIONER</b>	.....	.....
<b>DISTRICT NURSE</b>	.....	.....
<b>For Out of Hours Palliative Care advice for Health Professionals only contact: St. Leonards Hospice on 01904 708553</b>		

The Multi Professional Team have agreed the patient is dying, has two of the following symptoms and all other reversible causes have been ruled out: Please tick those that apply.

The patient is bed bound	<input type="checkbox"/>	Semi-Comatose	<input type="checkbox"/>
Only able to take sips of fluids	<input type="checkbox"/>	No longer able to take tablets	<input type="checkbox"/>

**The decision to put the above named patient on the LCP has been discussed with the patient's GP.**

**SIGNATURE..... POSITION HELD.....**

**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 (ie 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 references as necessary.
4. For any advice regarding the Pathway please contact the Project Leader/Macmillan Nurses on 01904 724476.



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**INITIAL ASSESSMENT**

**PATIENT'S NAME**.....

**DOB** .....

To be completed by the GP or Nurse.

Diagnosis:- Primary .....

Secondary .....

<b>SECTION 1</b>	
<b>COMFORT MEASURES:</b>	
1) Have current measures been assessed and non essential medications and interventions have been discontinued – bloods, BM's	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have appropriate oral drugs been converted to subcutaneous route?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2) Has appropriate PRN medication been prescribed (see flow charts)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
3a) Discontinue inappropriate interventions ie routine turning (turn for comfort only), vital signs etc.	Yes <input type="checkbox"/> No <input type="checkbox"/>
3b) Has patient got an internal cardiac defibrillator? Contact Specialist Cardiac team for advice.	Yes <input type="checkbox"/> No <input type="checkbox"/>
3c) Syringe Driver (as required) and anticipatory drugs available in the home	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>PSYCHOLOGICAL INSIGHT</b>	
4) <b>Ability to communicate?</b>	
Translator needed?	Patient Comatosed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
Special requirements?	Family/Carer Yes <input type="checkbox"/> No <input type="checkbox"/>
5) <b>Awareness of diagnosis</b>	
Patient	Comatosed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
Family/Carer	Yes <input type="checkbox"/> No <input type="checkbox"/>
Recognition of dying	Patient Comatosed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
Family/Carer	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>PHYSICAL CONDITION ( please circle those symptoms present)</b>	
Nausea	Aware
Vomiting	Conscious
Constipation	Urinary Tract problems
Diarrhoea	Catheterised
Faecal Incontinence	Excessive Respiratory Secretions
Pain	Breathlessness
Restlessness	Confusion
Oedema	Anxiety
Pressure Sores	Agitation
Other	Distressed

**SECTION 1 (Continued)**

**6) SPIRITUAL SUPPORT:**

- |                                                                                       |              |     |                          |    |                          |
|---------------------------------------------------------------------------------------|--------------|-----|--------------------------|----|--------------------------|
| a) Religious/spiritual needs assessed with patient/carer                              | Patient      | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|                                                                                       | Family/Carer | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| b) Any special requirements now, at time Of impending death, at death and after death | Patient      | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|                                                                                       | Family/Carer | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

Information and explanations given re: what to expect at time and following death:-

Family/Carers aware who to contact after death. Yes  No

**7) N/A for Community setting**

**8) N/A for Community setting**

**9) COMMUNICATION WITH PRIMARY HEALTHCARE TEAM**

**GP Practice is aware of patients condition**

GP Practice to be contacted if unaware patient is dying. Yes  No

**GP Out of Hours service aware and handover form completed**

Evening nursing service informed that patient on pathway Yes  No

**10) SUMMARY**

	Patient	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
<b>Plan of care discussed with:</b>	Family	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	Professional	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

**11) Family/other express understanding of planned care**

Family/other involvement in physical care Yes  No

Family/other aware that LCP Pathway commenced and their concerns identified Yes  No

Family/other offered carer support/night sitters Yes  No

Not to call emergency ambulance discussed Yes  No

Not to attempt to resuscitate discussed Yes  No

If post mortem required, family aware Yes  No

Contact numbers for 24 hour care and advice discussed Yes  No

**Date:.....**

**Health Professional Signature.....**

**CONTINUOUS ASSESSMENT**

**PATIENT'S NAME.....**

**DOB .....**

<b>A Achieved</b>	<b>V Variance</b>	<b>N/A Not applicable</b>
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<b>SECTION 2</b>									
	GOAL	Date	Date	Date	Date	Date	Date	Date	Date
		Time	Time	Time	Time	Time	Time	Time	Time
a)	<b>Pain</b> <b>The Patient is pain free</b> <ul style="list-style-type: none"> <li>• Verbalised by the patient if conscious</li> <li>• Pain free on movement</li> <li>• Appears peaceful</li> <li>• Move only for comfort</li> </ul>								
b)	<b>Agitation</b> <b>The Patient is not agitated</b> <ul style="list-style-type: none"> <li>• The patient is not twitching, restless, thrashing, plucking or showing signs of anguish</li> <li>• Exclude retention of urine as a cause</li> </ul>								
c)	<b>Respiratory Tract</b> <b>The Patient's breathing is not made difficult by excessive secretions</b> <ul style="list-style-type: none"> <li>• Medication to be given as symptoms arise</li> <li>• Symptoms discussed with family/other</li> </ul>								
d)	<b>Nausea and Vomiting</b> <b>The Patient does not have nausea or vomiting</b> <ul style="list-style-type: none"> <li>• The patient verbalises if conscious</li> </ul>								
e)	<b>Other Symptoms</b> <b>The Patient does not have any other symptoms (See Care Plans)</b> <ul style="list-style-type: none"> <li>• Eg dyspnoea, myoclonic jerks, wound care, pressures sores, etc</li> </ul>								
f)	<b>Mouth Care</b> <b>The Patient's mouth is moist and free from discomfort</b> <ul style="list-style-type: none"> <li>• Four hourly mouth care in process.</li> </ul>								
g)	<b>Micturition Difficulties</b> <b>The Patient's continence needs have been assessed</b> <ul style="list-style-type: none"> <li>• He/she is dry and comfortable</li> <li>• Urinary catheter if in retention</li> <li>• Urinary catheter or pads, if general weakness creates incontinence</li> </ul>								
h)	<b>The Patient is comfortable re bowel care</b> <ul style="list-style-type: none"> <li>• No agitation due to constipation or diarrhoea</li> <li>• Faecal incontinence/soiling</li> </ul>								
i)	<b>Movement</b> <b>Mobility/Pressure areas</b> <ul style="list-style-type: none"> <li>• The patient is in a safe environment</li> <li>• The patient is comfortable, use of appropriate pressure relieving aids eg special mattress</li> </ul>								
<b>Signature</b>									

This can be filled by all health professionals.  
 If you have checked 'V' against any goal so far please complete Variance Sheet.

**CONTINUOUS ASSESSMENT**

**PATIENT'S NAME**.....  
**DOB** .....

<b>A Achieved</b>	<b>V Variance</b>	<b>N/A Not applicable</b>
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<b>SECTION 2 (Continued)</b>									
		Date	Date	Date	Date	Date	Date	Date	Date
		Time	Time	Time	Time	Time	Time	Time	Time
j)	<b>Psychological Support</b> <b>The Patient is informed of all procedures</b> <ul style="list-style-type: none"> <li>• Touch, verbal communication to continue</li> </ul>								
k)	<b>Medication</b> <b>All syringe driver medication given safely and accurately (refer to syringe driver documentation)</b> <ul style="list-style-type: none"> <li>• GP prescribed medication for 48 hours. If breakthrough medication been given in the past 24 hours contact GP (drugs changed as per flow chart)</li> <li>• NB breakthrough medication altered accordingly</li> </ul>								
l)	<b>Family/Other</b> <b>Family/Other are prepared for the patient's imminent death with the aim of achieving peace of mind and acceptance</b> <ul style="list-style-type: none"> <li>• Check understanding of nominated family/others</li> <li>• Check understanding of other family/others not present at initial assessment</li> <li>• Recognition of patient dying and measures taken to maintain comfort</li> <li>• Explain possibility of family/others physical symptoms eg fatigue</li> <li>• Psychological symptoms such as anxiety/depression</li> </ul>								
m)	<b>Religious/Spiritual support</b> <b>Appropriate religious/spiritual support has been given</b> <ul style="list-style-type: none"> <li>• Patient/other may be anxious for self/others</li> </ul>								
n)	<b>Care of the family/others</b> <b>The needs of those attending the patient are accommodated</b> <ul style="list-style-type: none"> <li>• Consider health needs and social support</li> </ul>								
<b>Signature</b>									

This can be filled by all health professionals.  
 If you have checked 'V' against any goal so far please complete Variance Sheet.



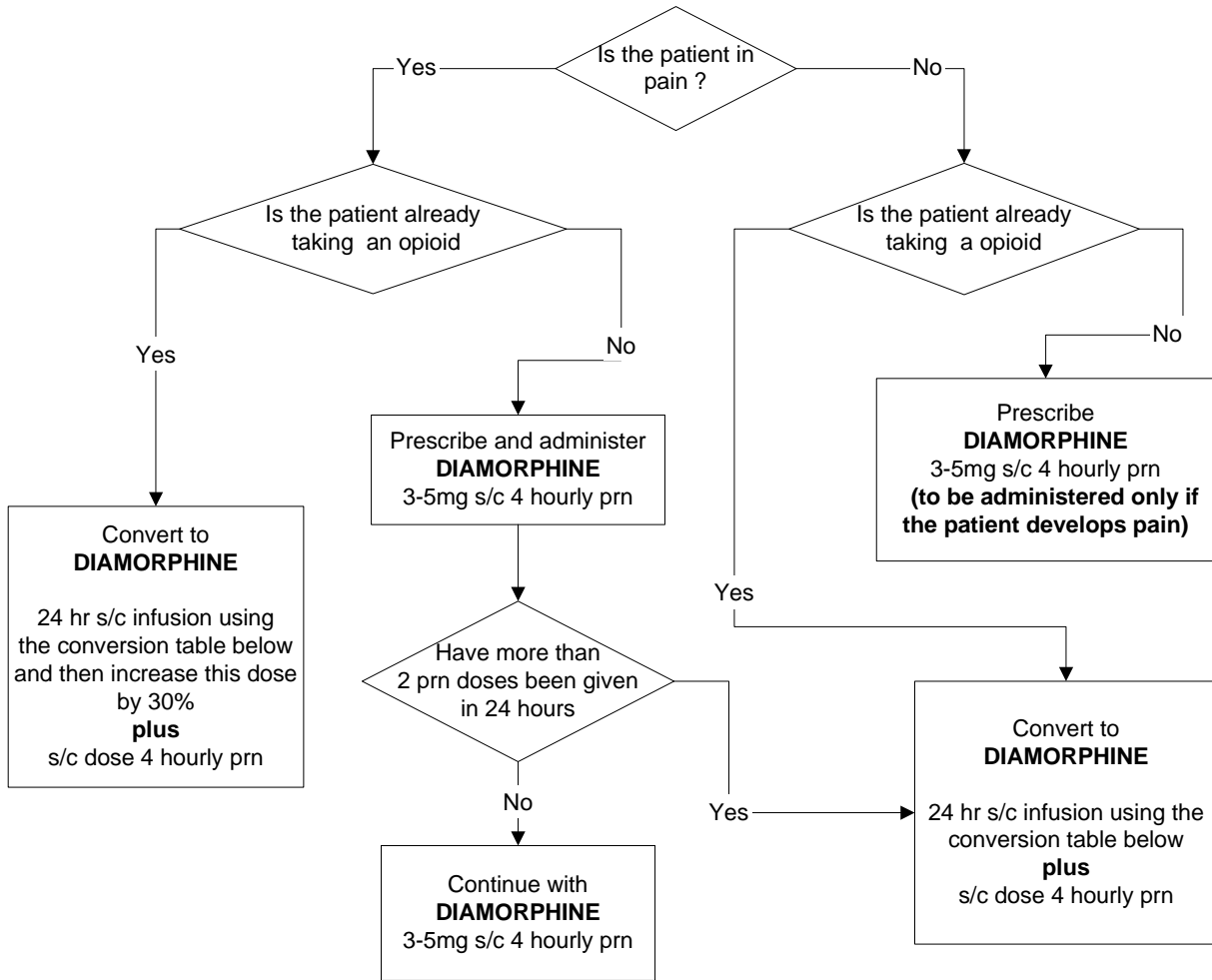








## PAIN

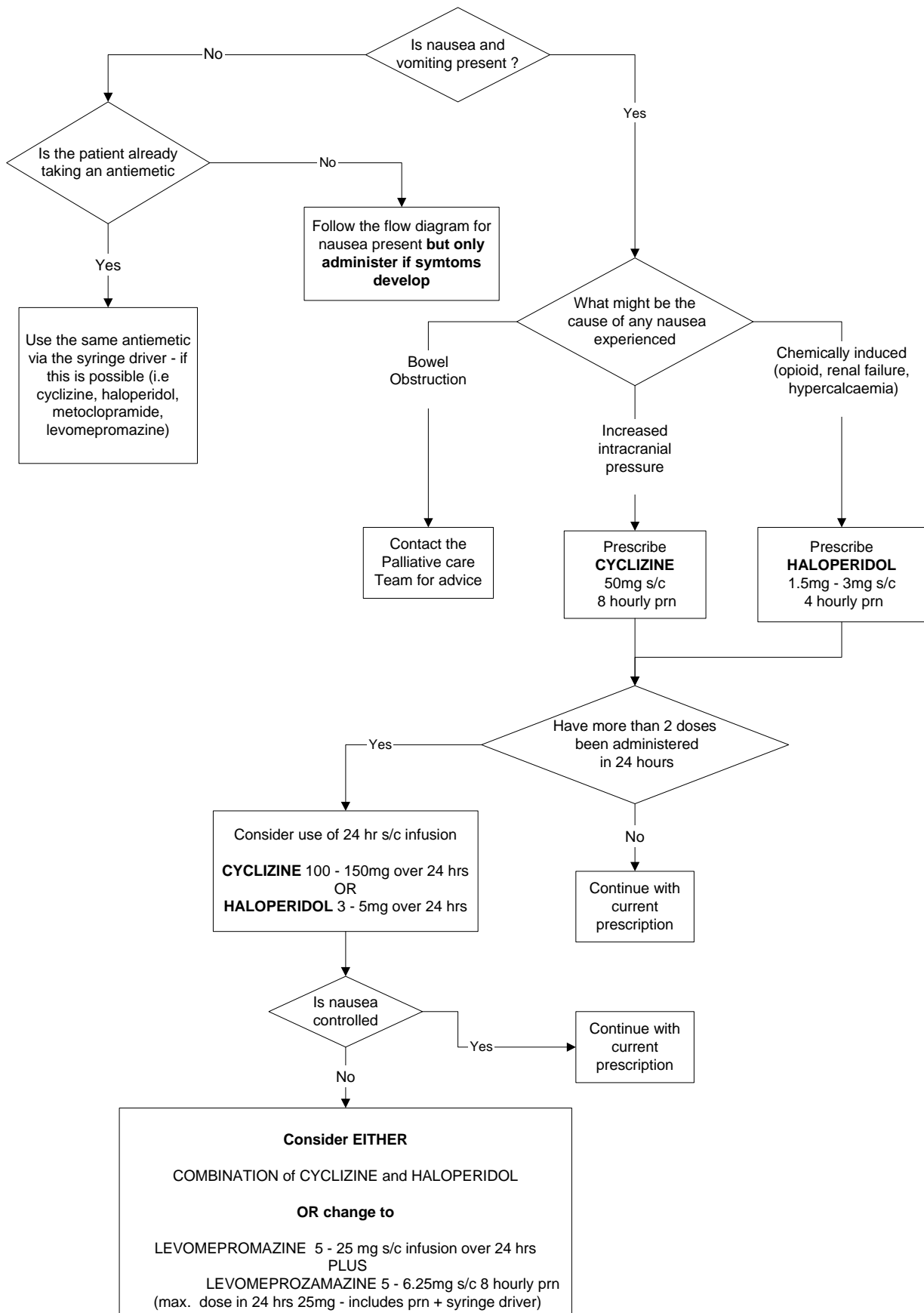


**To calculate the prn dose of diamorphine**  
 Prescribe 1/6th of the 24 hr dose in the driver  
 e.g 20mg s/c via driver over 24 hrs will require  
 3 - 5mg 4 hourly prn

Strong opioid	Conversion to s/c diamorphine over 24 hours	Example
Morphine/ MST/ Oramorph/ Zomorph	Divide total morphine dose by 3	Zomorph 30mg bd = 20mg Diamorphine s/c over 24 hrs
Fentanyl patch	Leave patch on and top up with diamorphine in syringe driver (usually 1/5 strength of patch)  Diamorphine dose (mg) in 24 hours is approximately equivalent to the patch strength (mcg)	Fentanyl patch 75 mcg every 72 hrs is approx equivalent to 75mg diamorphine s/c over 24 hrs  Top up dose in syringe driver is 1/5 <sup>th</sup> patch strength = 15mg diamorphine Breakthrough dose is initially 15mg. Will need increasing as diamorphine requirements increase

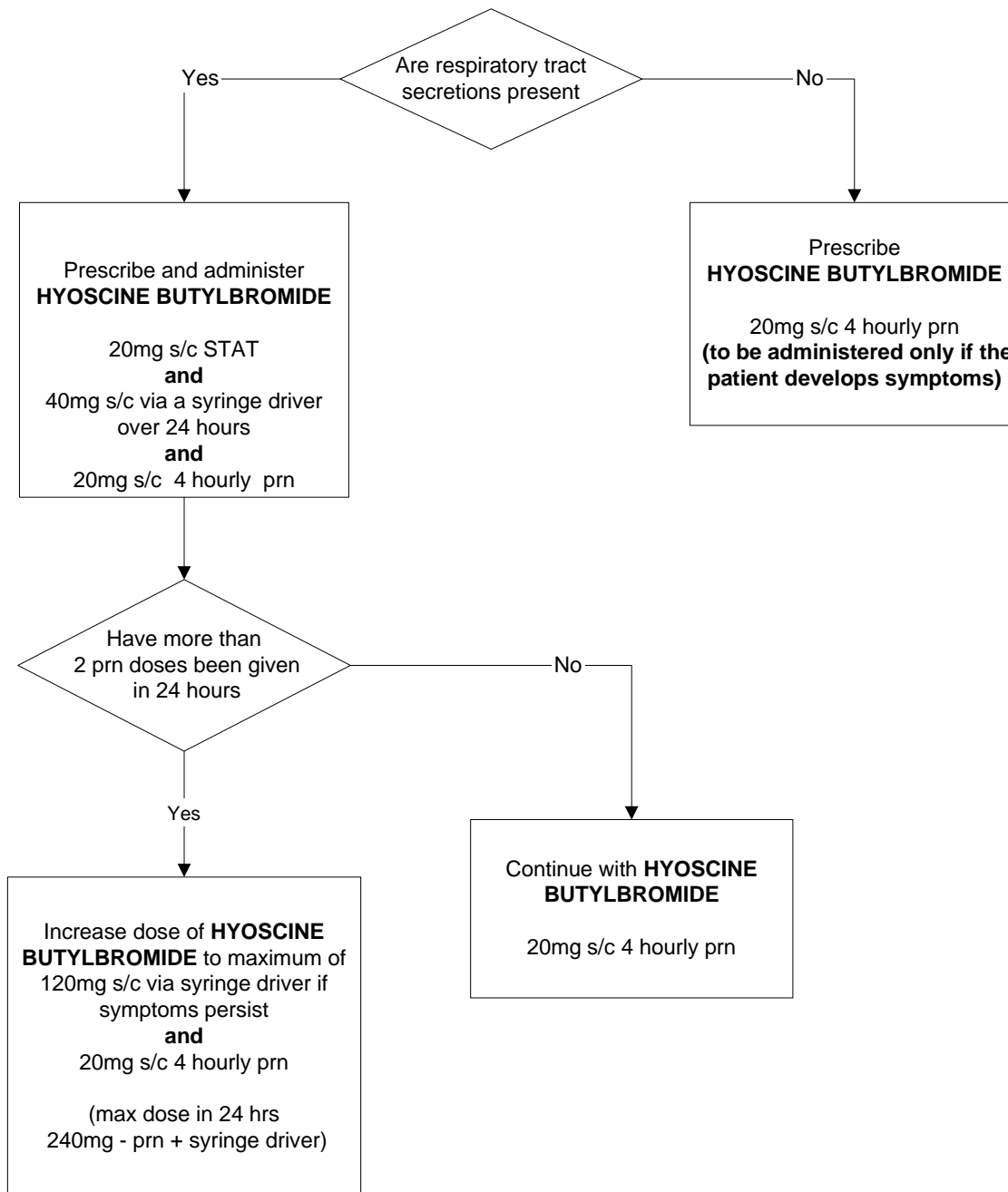
**Remember to include prn doses in your calculations**

## NAUSEA AND VOMITING



## RESPIRATORY TRACT SECRETIONS

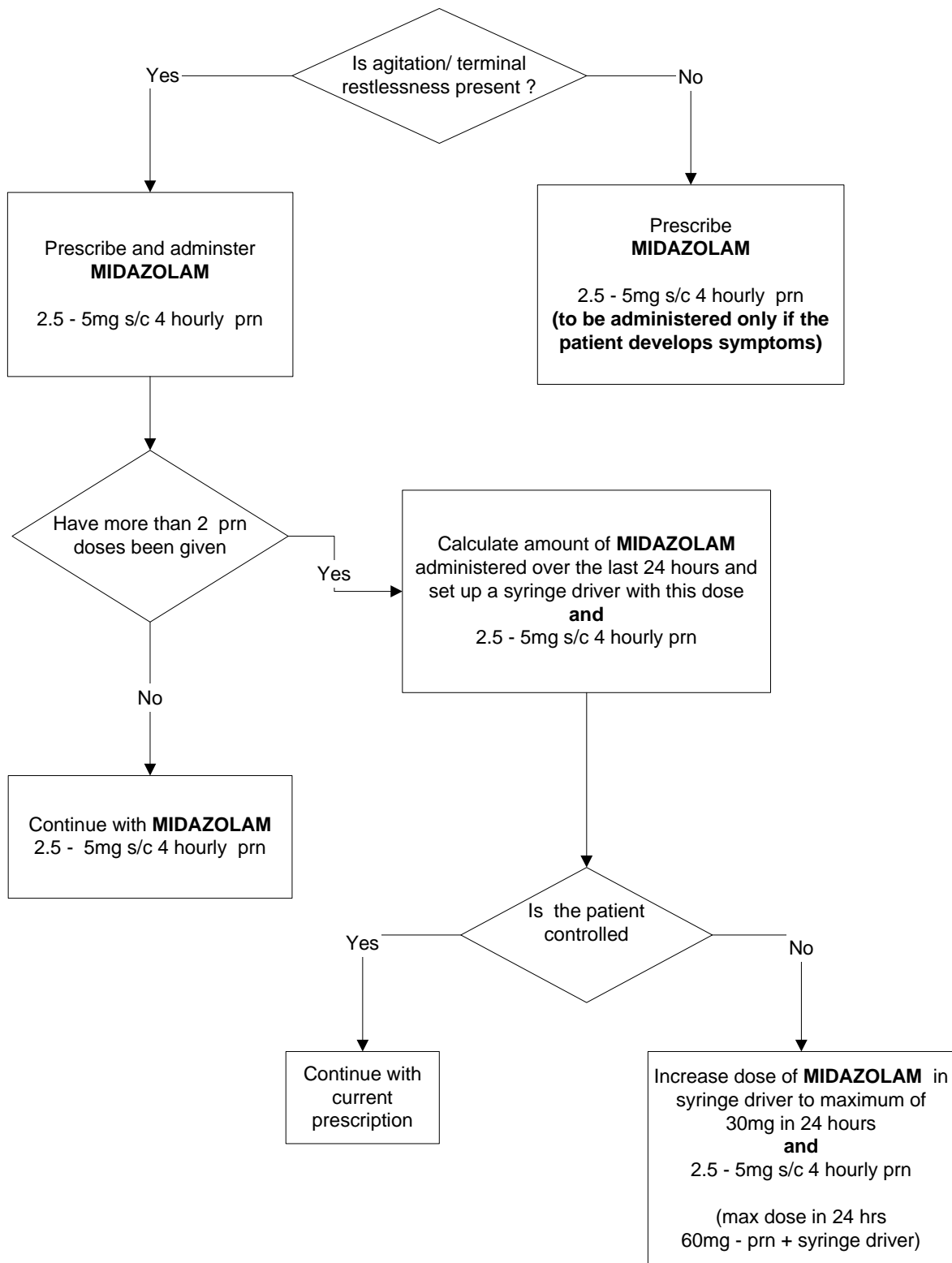
(Remember you cannot clear existing secretions, but you can help stop further production)



### **NOTE**

**HYOSCINE BUTYL BROMIDE** is less sedating than **HYOSCINE HYDROBROMIDE** and less expensive. It occasionally can precipitate when mixed with **CYCLIZINE**. If problems discuss with pharmacy

## AGITATION / TERMINAL RESTLESSNESS



## CHOICE OF DRUGS FOR USE IN SYRINGE DRIVERS (USUAL DOSE RANGES QUOTED)

**Note DIAMORPHINE**  
Parenteral Diamorphine is 3 x stronger than oral morphine. If pain not controlled, increase dose by 30% to 50%

DRUG	USE	STAT DOSE S/C	24 HRS S/C DOSE IN SYRINGE DRIVER (SD)	MAX DOSE IN 24 HRS (PRN + SD)
<b>Anti emetic</b>				
CYCLIZINE 50mg in 1ml	Centrally acting on vomiting centre. Good for nausea associated with bowel obstruction or increased intracranial pressure Dilute with water	50mg	100 - 150mg	150mg
HALOPERIDOL 5mg in 1ml	Good for chemically induced nausea	1.5 - 3mg	3 - 5mg	5mg
METOCLOPRAMIDE 10mg in 2ml	Antiemetic (1) prokinetic (accelerates GI transit) (2) centrally acting on chemo-receptor trigger zone (CTZ), blocking transmission to vomiting centre	10mg	40 - 60mg	120mg
LEVOMEPRMAZINE 25mg in 1ml	Broad spectrum antiemetic, works on CTZ and vomiting centre (at lower doses)  Dilute with saline when used alone	5 - 6.25mg	5 - 25mg	25mg
<b>Anti-agitation</b>				
MIDAZOLAM 10mg in 2ml	Sedative/anxiolytic (terminal agitation). Also anticonvulsant and muscle relaxant	2.5 - 5mg	5 - 30mg	60mg
<b>Antisecretory</b>				
HYOSCINE BUTYLBROMIDE 20mg in 1ml	Antisecretory - useful in reducing respiratory tract secretions Also has antispasmodic properties  May precipitate when mixed with CYCLIZINE or HALOPERIDOL Less sedating than HYOSCINE HYDROBROMIDE	20mg	40 - 120mg	240mg
HYOSCINE HYDROBROMIDE 400mcg in 1ml	Antisecretory - useful in reducing respiratory tract secretions Also has antispasmodic properties	400mcg	400mcg - 2.4mg	2.4mg