Comfort Observations

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Ambitions for Palliative and End of Life Care

Attach patient ID label here

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Guidance: caring for the dying patient

Updated October 2020 V3

Recognition and communication:

The recognition that the patient is dying should be made by the senior responsible clinician in consultation with the patient/ family and clinical team.

- This should be communicated to the patient, if possible and the relatives/carers if appropriate
- Likely timescale should be explained and any uncertainty around this
- Out of hours, if the situation has not been anticipated, the decision making can be delegated to a Registrar, another Consultant or on-call GP.

Individualised end of life care plan:

Make a plan with the patient, if possible and involve the relatives/carers if appropriate.
Document the plan and any significant conversations in the case notes.

- Identify any relevant decisions made in advance (e.g. ADRT/DNACPR/EHCP, etc.)
- Explore and document their understanding and any concerns
- Establish preferred place of death; explore transfer options if not current care setting and patient well enough to benefit from transfer
- Decide on appropriate monitoring, investigations and interventions
  - For most patients it will be appropriate to stop routine observations and blood tests
  - Commence comfort observations on Nervecentre (Hospitals only)
  - Patients should not have investigations that will not change management
  - If the patient is diabetic, make a plan for management of this (see NECN Palliative and End of Life Guidelines)
- Assess symptoms and agree a plan for management of current and likely future symptoms
  - Explain anticipatory sc prn medication will be prescribed for common symptoms; they might not be needed but are there to ensure comfort. If needed, the smallest effective dose will be used
  - Explain potential sedative side effects of these medications
  - If a syringe driver is being used explain this and the reason for it
  - Ensure medications and all equipment needed are available
  - Discontinue non-essential medications, this is usually any that will not help comfort
- Discuss pros and cons of hydration and nutrition options and agree a plan
  - Explain reduced need for food and fluids in a dying patient and importance of good regular mouth care
  - Patient should be offered food and drink regularly if they are able to swallow
- Identify what is important to the patient, including spiritual needs and care after death needs.
  - Contact chaplain if indicated

Please seek advice from the specialist palliative care team if:

- There are concerns or difficult to control symptoms.
- Symptoms not settling
- Approaching maximum recommended doses of medications. Patients may require higher doses or more frequent injections but this should be following medical review or specialist advice

Community Palliative Care Teams:

North Durham: 01207 523673
Easington: 0191 5692875
Durham Dales, Sedgefield and Darlington:
01388 455100

Hospital Palliative Care Teams:

UHND: 0191 3332338
DMH & BAH: 01325 743336

Out of Hours Advice for Health Professionals: Monday – Friday 17:00 – 09:00 hours
Weekends and Bank Holiday 24 hours
07917 581 089

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Ongoing management and responsibilities

Patients need to be assessed regularly, including for any improvement. The plan should be modified according to their needs. **Regular communication with families/carers is essential.**

Acute and Community Hospitals:

- At least 4 hourly nursing assessment documented in the care record and on the comfort observation module on Nervecentre
  - Follow NECN symptom control guidelines and escalation instructions on Nervecentre
- At least daily medical/nursing assessment documented in the care record to include:
  - Has there been a significant change in condition?
  - Do the nursing staff have any concerns?
  - Explore patient/ relative/ carer concerns or questions.
  - Review use of PRN medications and consider whether syringe driver is needed or doses need adjusting.
  - Assess for issues relating to hydration, nutrition, continence, cognitive status
  - Examination: mouth, skin, presence or absence of pain/ distress/ upper resp. secretions/ breathlessness/ nausea/ vomiting
  - Are spiritual care needs and the needs of the carer being met?
  - Is the patient in their preferred place of death? If not explore whether this is possible.
  - Do you need to discuss this patient with a more senior colleague or seek the support of the specialist palliative care team?
  - Hand over any key information to other team members
- Regular assessment by the senior responsible clinician documented in the care record

Community:

- At least daily nursing assessment documented in the care record (as above)
- Regular assessment by the senior responsible clinician documented in the care record.

Symptom control in dying patients:
Anticipatory prescribing – 'as required' subcutaneous injections

Symptom	Drug	Dose	Frequency/ Total Dose
Pain	Morphine	2.5-5mg	1 hourly
	NB. For patients currently taking opioid or with renal impairment or morphine intolerance the dose/drug rill need to be adjusted - see NECN guidelines		
Nausea & Vomiting	Levomepromazine	6.25mg	1 hourly, max 25mg/ 24hrs
Agitation / restlessness	Midazolam	2.5-5 mg	1 hourly
	Levomepromazine (delirium)	12.5 mg	1 hourly, max 75mg/ 24hrs
Respiratory secretions	Hyoscine Butylbromide	20 mg	1 hourly, max 120mg/24hrs
Dyspnoea	Morphine +/- Midazolam	See above	

T34 syringe pump prescribing:

- Full individualised assessment required to determine a starting dose or convert oral medication to subcutaneous medication

For more information see North of England Clinical Network Palliative and End of Life Care Guidelines
http://www.northerncanceralliance.nhs.uk/wp-content/uploads/2018/11/NECNXPALLIATIVEXCAREX2016.pdf

PLEASE SEEK PALLIATIVE CARE TEAM ADVICE IF SYMPTOMS NOT SETTLING AND / OR APPROACHING MAXIMUM RECOMMENDED DOSES.
PATIENTS MAY REQUIRE HIGHER DOSES OR MORE FREQUENT INJECTIONS

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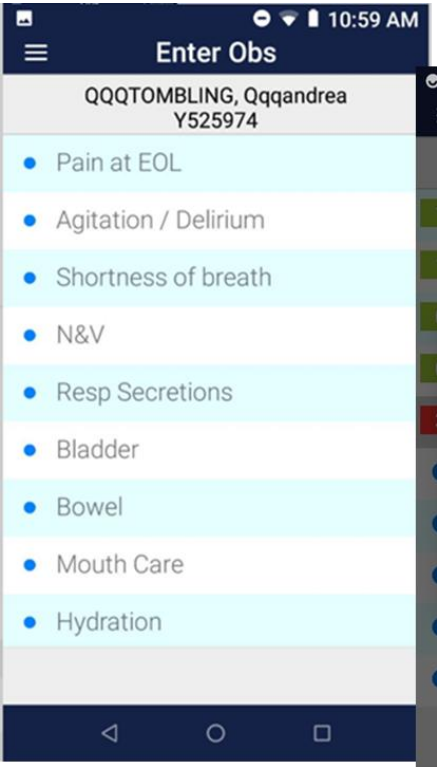
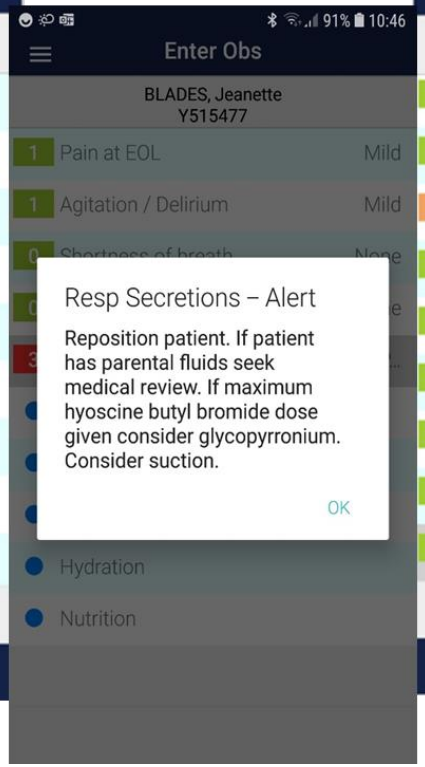
Physiological parameter	Score 3	2	1	0	1	2	3
Respiration rate (per minute)	≤8		9–11	12–20		21–24	≥25
SpO_2 Scale 1 (%)	≤91	92–93	94–95	≥96			
SpO_2 Scale 2 (%)	≤83	84–85	86–87	88–92 ≥93 on air	93–94 on oxygen	95–96 on oxygen	≥ ox
Air or oxygen?		Oxygen		Air			
Systolic blood pressure (mmHg)	≤90	91–100	101–110	111–219			≥
Pulse (per minute)	≤40		41–50	51–90	91–110	111–130	≥
Consciousness				Alert			C
Temperature (°C)	≤35.0		35.1–36.0	36.1–38.0	38.1–39.0	≥39.1	

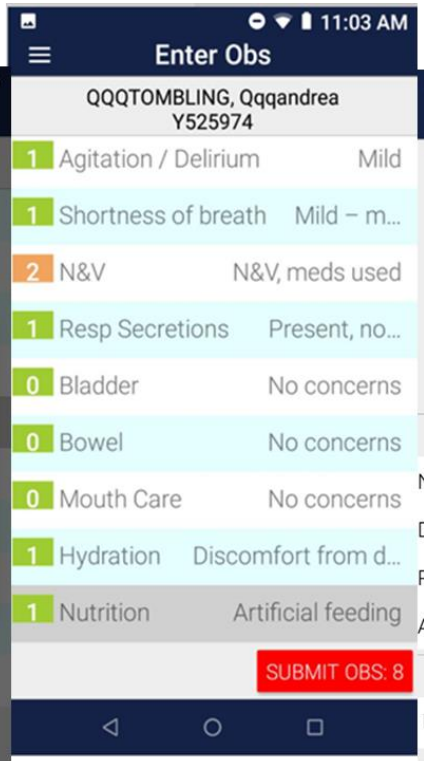
NEW score	Frequency of monitoring	Clinical response
0	Minimum 12 hourly	• Continue routine NEWS monitoring
Total 1–4	Minimum 4–6 hourly	• Inform registered nurse, who must assess the patient • Registered nurse decides whether increased frequency of monitoring and/or escalation of care is required
3 in single parameter	Minimum 1 hourly	• Registered nurse to inform medical team caring for the patient, who will review and decide whether escalation of care is necessary
Total 5 or more Urgent response threshold	Minimum 1 hourly	• Registered nurse to immediately inform the medical team caring for the patient • Registered nurse to request urgent assessment by a clinician or team with core competencies in the care of acutely ill patients • Provide clinical care in an environment with monitoring facilities
Total 7 or more Emergency response threshold	Continuous monitoring of vital signs	• Registered nurse to immediately inform the medical team caring for the patient – this should be at least at specialist registrar level • Emergency assessment by a team with critical care competencies, including practitioner(s) with advanced airway management skills • Consider transfer of care to a level 2 or 3 clinical care facility, ie higher-dependency unit or ICU • Clinical care in an environment with monitoring facilities

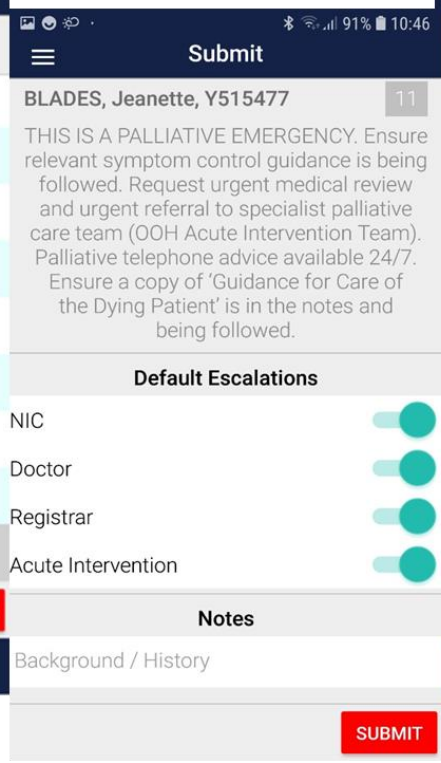
Symptom	Observation			
	0	1	2	3
Pain at EOL	None	Mild	Moderate	Severe
Agitation/delirium	None	Mild	Moderate	Severe
Shortness of breath	None	Mild - mod, no meds used	Mild – mod + meds used	Severe
N&V	None	N&V, no meds used	N&V, meds used	N&V +driver +max PRN
Resp Secretions	None	Present, no meds used	Present, + meds used	Present +driver +PRNs
Bladder	No concerns	Palpable/inco + skin issues		
Bowel	No concerns	Inco +skin integrity issue	Not open +discomfort	
Mouth care	No concerns	Crusted + discomfort		
Hydration	No concerns	Discomfort from dehydration	IVT +oedema/secretions	
Nutrition	No concerns	Artificial feeding	Family concern	

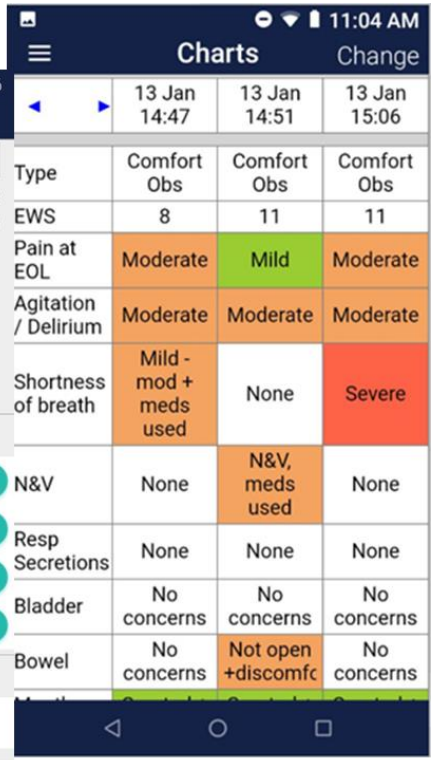
	Recorder actions
0-2	Observations indicate the patient is stable. Ensure a copy of 'Guidance - Caring for the Dying Patient' is in the notes and follow guidance for relevant symptoms. If you have clinical concerns please inform your medical team
3-5 Threat	At risk of worsening symptoms. Consider seeking specialist palliative care advice. Ensure a copy of 'Guidance - Caring for the Dying Patient' is in the notes and follow guidance for relevant symptoms.
6-8 (or any 3 in 1 parameter) Sick	Follow guidance for relevant symptoms, request medical review and consider palliative care team (or OOH Acute Intervention Team) review. Palliative telephone advice available 24/7. Ensure a copy of 'Guidance - Caring for the Dying Patient' is in the notes and being followed.
9+ Now	THIS IS A PALLIATIVE EMERGENCY. Ensure relevant symptom control guidance is being followed. Request urgent medical review and urgent referral to specialist palliative care team (OOH Acute Intervention Team). Palliative telephone advice available 24/7. Ensure a copy of 'Guidance for Care of the Dying Patient' is in the notes and being followed.

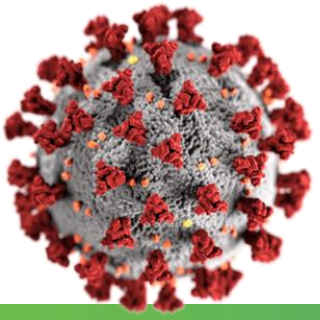




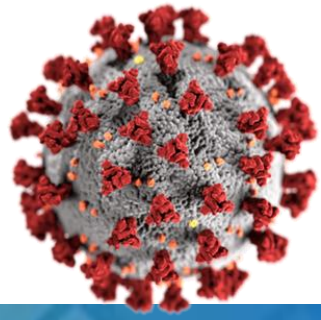








January 2021



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CDDFT Digital

www.cddft.nhs.net

QQQTOMBLING, Qqqandrea ▾

Y525974

NIV IC19

DoB / Age / Gender	Ward / Bed ▼	Admitted	Consultant / Specialty
23 Apr 1972	DMH WARD 34	15 Jul 2020	Gatnash, Abdelhakim, DR
49y Female	Bay1-Bed1	591 days	GENERAL MEDICINE

Summary | Clinical

COVID19 Status

Screened Positive

COVID19 Vaccination Status

Flu Status

Microbiology / Infection

Rockwood Score

4 Vulnerable

Allergies

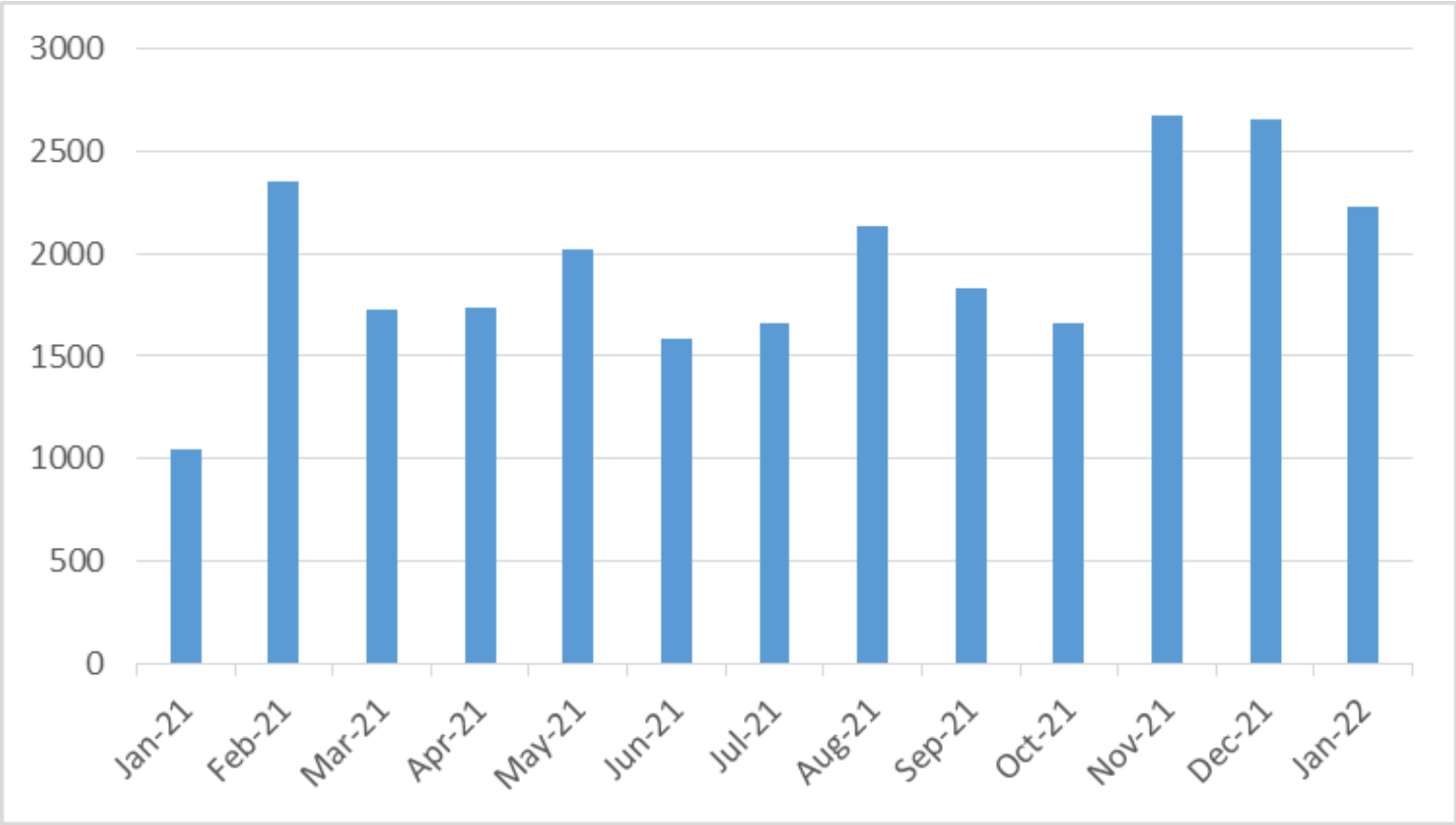
Oxygen Device	Air	Air	
BP	123/69 mmHg	123/69 mmHg	
Heart Rate	65 /min	65 /min	
ACVPU	Alert	Alert	
Temperature	36.9 °C	36.9 °C	
Skin Perfusion	Mottled	Normal Appearance	
Urine	Passed Urine within 6 hours	On fluid balance chart – see chart	
Pain at EOL			Mild
Agitation / Delirium			Mild
Shortness of breath			Mild – mod, no meds used
N&V			N&V, meds used
Resp Secretions			Present, no meds used
Bladder			No concerns
Bowel			No concerns
Mouth Care			No concerns
Hydration			Discomfort from dehydration
Nutrition			Artificial feeding
Nurse Notes			

•••	Not Assigned	14/01 11:04
Unallocated •••	Not Assigned	Created 14/01 11:24
Obs Due •••	Not Assigned	Created 14/01 11:48
Task Overdue •••	Not Assigned	Created 14/01 12:08
Obs Overdue •••	Not Assigned	Created 14/01 12:18

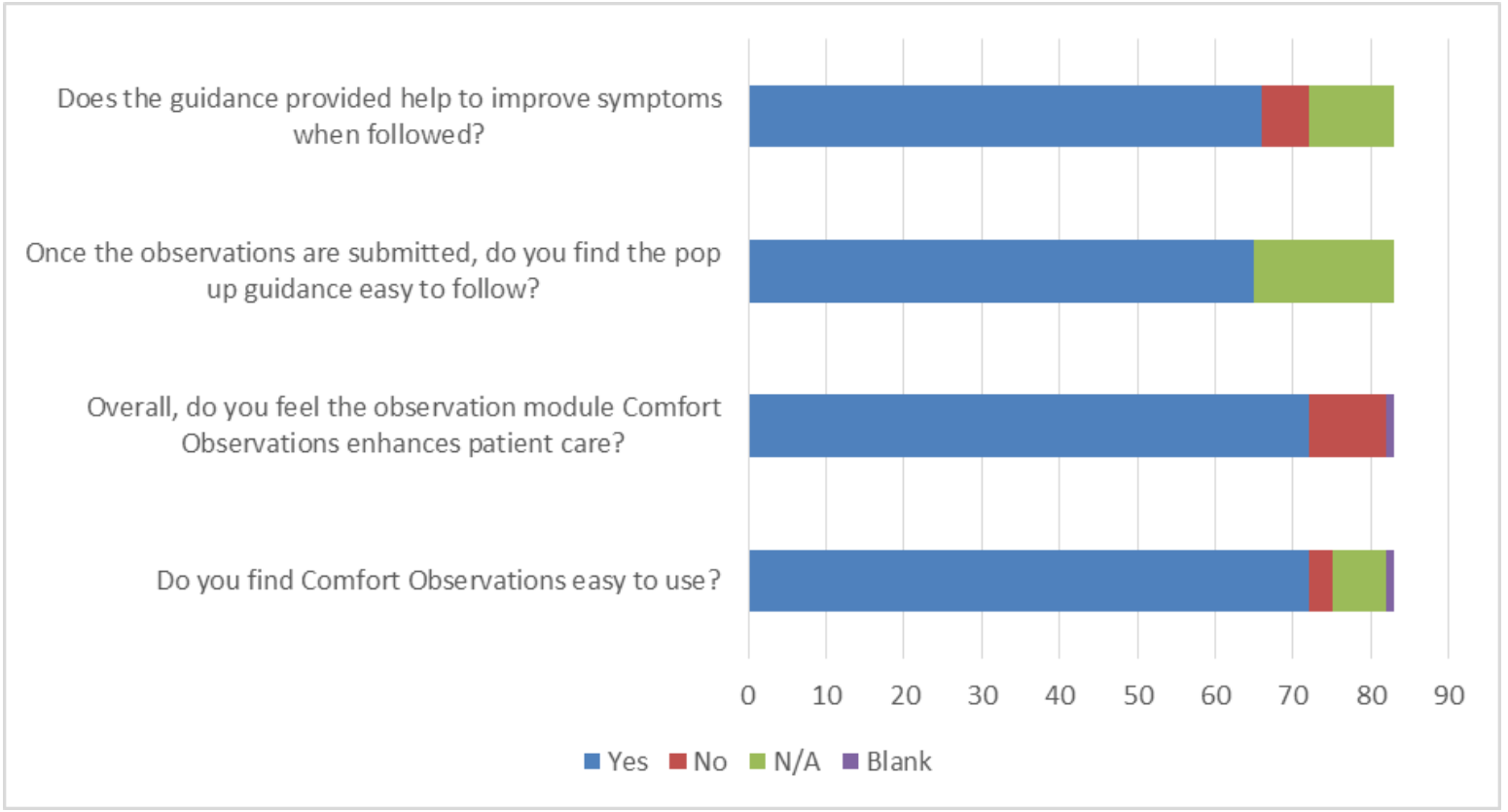
Staff

Visit History

Comfort Observation Score	Count
0	18689
1	3290
2	1873
3	754
4	390
5	186
6	69
7	27
8	24
9	1
10	2
11	0
12	1
13	2
Total	25308



	Yes	No	N/A	Blank
Do you find Comfort Observations easy to use?	72	3	7	1
Overall, do you feel the observation module Comfort Observations enhances patient care?	72	10	0	1
Once the observations are submitted, do you find the pop up guidance easy to follow?	65	0	18	0
Does the guidance provided help to improve symptoms when followed?	66	6	11	0



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'How people die remains in the memory of those who live on.'

Dame Cicely Saunders