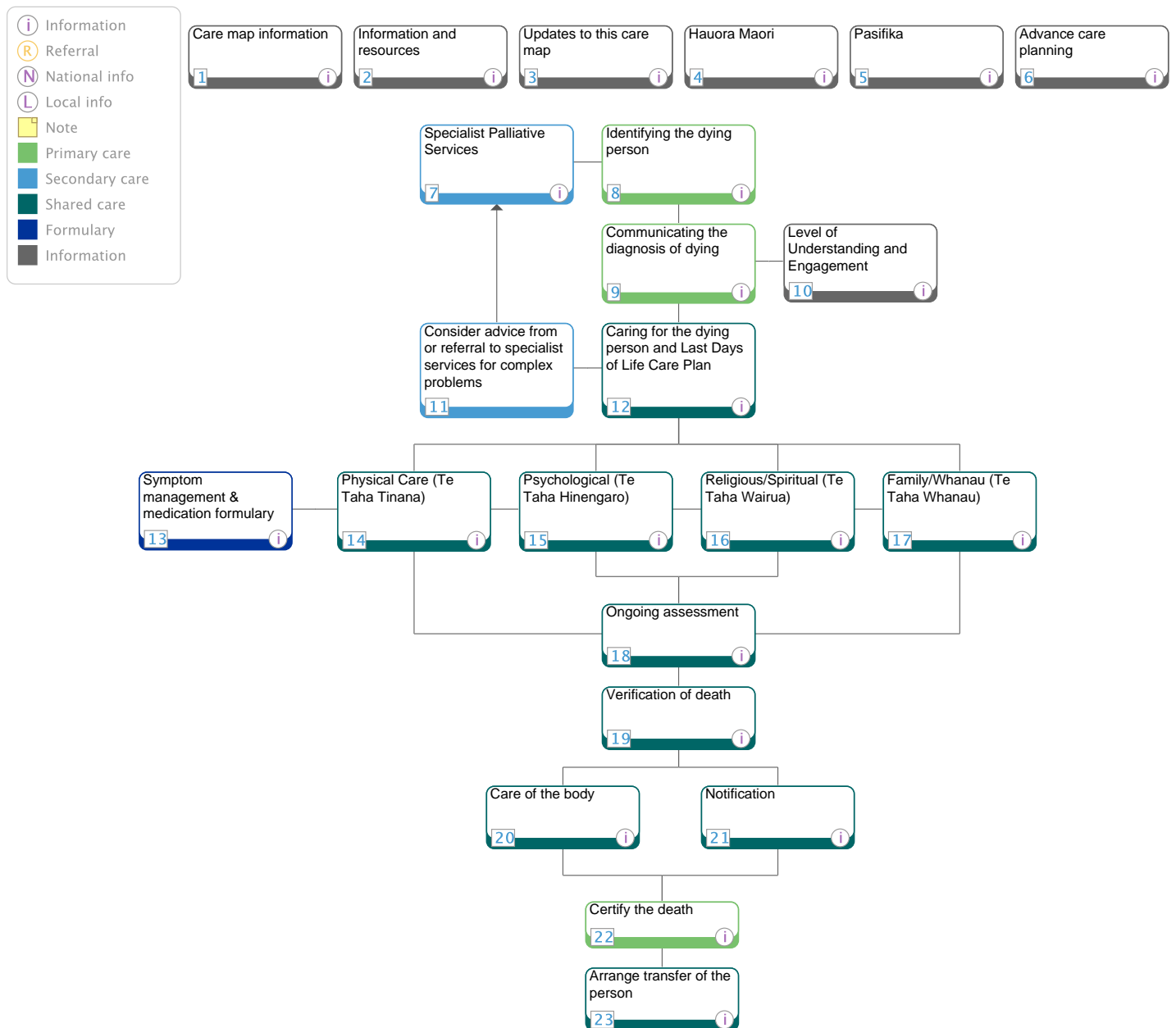


Last Days of Life - Adults

Medicine > Palliative Care > Palliative Care



Last Days of Life - Adults

Medicine > Palliative Care > Palliative Care

1 Care map information

Quick info:

In scope:

- an adult identified as approaching the last days of life
- the person's family/whanau or carer

Out of scope:

- children - 18 years of age and under

[A really practical handbook for Children's Palliative care for doctors and nurses anywhere in the world](#)

Definition and principles

Last days of life defines a period when a person is dying. It is a period of time when death is imminent and may be measured in hours or days (Palliative Care Council 2015):

- recognition of the beginning of the last days of life can vary according to the individual and professional perspectives
- signs and symptoms are often subtle
- health professionals should identify as early as possible that a person is dying, as this gives time to prioritise provisions of comfort and support based on the person's preferences
- in all cases, comprehensive assessment and care planning with the person's consent and input (whether that be directly with the person or through advance care plans) should take place as soon as the Last Days of Life are recognised
- the person and the family/whanau should be provided with information and support to meet the last days of life care preferences. This may or may not require referral or consultation with other services **Note:** There will always be a degree of uncertainty over the timing of a person's death (and there may be a chance that their condition will improve), but this should not preclude anticipatory discussions and the implementation of holistic person-centred care.

[Te Ara Whakapiri Principles and Guidance for the Last Days of Life](#)

The seven principles to achieving excellence and consistency of care for people in their last days of life are:

- care is person-centred
- the workforce providing the care is the right workforce
- communication is clear and respectful
- services providing care to people in their last days of life are integrated, and move with the person
- services are sustainable
- services are nationally guided and supported, to improve consistency and reduce unacceptable variation in access, including for geographic reasons
- access to resources and equipment is consistent nationally

2 Information and resources

Quick info:

[Te ara Whakapiri - Principles and guidance for the last days of life.](#)

[Last days of Life Care Plan](#)

[Last days of Life Plan Toolkit](#)

References:

- National End of Life Programme. The route to success in end of life care - achieving quality in acute hospitals. London: Department of Health (DH); 2010
- Leadership Alliance for the Care of Dying People (LACDP). One chance to get it right: improving people's experience of care in the last few days and hours of life. London: LACDP; June, 2014
- National Institute for Health and Clinical Excellence (NICE). Improving supportive and palliative care for adults with cancer – the manual. London: NICE; 2004

3 Updates to this care map

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Date of publication September 2016

Review date: March 2017

This care map has been developed in line with consideration to evidenced based guidelines. For further information on contributors and references please see the Pathway's Provenance Certificate.

NB: This information appears on each page of this care map.

4 Hauora Maori

Quick info:

Maori are a diverse people and whilst there is no single Maori identity, it is vital practitioners offer culturally appropriate care when working with Maori whanau. It is important for practitioners to have a baseline understanding of the issues surrounding Maori health. This knowledge can be actualised by (not in any order of priority):

- considering the importance of introductions ('whanungatanga') - a process that enables the exchange of information to support interaction and meaningful connections between individuals and groups. This means taking a little time to ask where this person is from or to where they have significant connections
- asking Maori people if they would like their whanau or significant others to be involved in assessment and treatment
- asking Maori people about any particular cultural beliefs they or their whanau have that might impact on assessment and treatment of the particular health issues
- "For Maori, death and dying it is deeply imbued with cultural significance, and it is not uncommon even for Maori who are otherwise relatively unobservant to follow very traditional practices when they or loved ones are near death" [1]

Maori health services

HBDHB contracts Maori health providers to deliver community based nursing and social support services. A referral to one of these providers may assist Maori people to feel more comfortable about receiving these services.

Central Hawke's Bay:

[Central Health](#)

Cnr Herbert & Ruataniwha Streets, Waipukurau

Phone: 06 858 9559 Fax: 06 858 9229

Email: reception@centralhealth.co.nz

[Referral Form](#)

Hastings:

[Te Taiwhenua o Heretaunga](#)

821 Orchard Road, Hastings 4156

Phone: 06 871 5350 Fax: 06 871 535

Email: taiwhenua.heretaunga@ttoh.iwi.nz

[Referral Form](#)

[Kahungunu Health Services](#) (Choices)

500 Maraekakaho Road, Hastings

Phone: 06 878 7616

Email: kahungunu@paradise.net.nz

[Referral Form](#)

Napier:

[Te Kupenga Hauora](#)

5 Sale Street, Napier

Phone: 06 835 1840

Email: info@tkh.org.nz

[Referral Form](#)

Wairoa:

Kahungunu Executive (no website)

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65 Queen Street, Wairoa 4108

Phone: 06 838 6835 Fax: 06 838 7290

Email: kahu-exec@xtra.co.nz

Secondary care Maori Health Services:

Hawke's Bay DHB - Te Wahanga Hauora Maori Health Services

Phone: 06 878 8109 ext. 5779, 06 878 1654 or 0800 333 671 Email: admin.maorihealth@hawkesbaydhb.govt.nz

Further Information

Practitioners should be versed in the knowledge of:

- historical overview of legislation that impacted on Maori well-being
- Maori models of health, such as [Te Whare Tapa Wha](#) and Te Wheke when working with Maori whanau
- national Maori Health Strategies:
 - **Mai Maori Health Strategy 2014-2019** - [Full file](#) or [Summary diagram](#)
 - **He Korowai Oranga:** Maori Health Strategy - sets the [Government's overarching framework](#) to achieving the best health outcomes for Maori
- local [Hawke's Bay health sector's strategies and initiatives](#) for improving Maori health and wellbeing

Cultural Competency Training

Training is available through the Hawke's Bay DHB to assist you to better understand Maori culture and to better engage with Maori people. Contact the coordinator, via email: education@hbdhb.govt.nz, to request details of the next courses.

5 Pasifika

Quick info:

Pacific people value their culture, language, families, education and their health and wellbeing. Many Pacific families have a religious affiliation to a local church group.

The Pacific people are a diverse and dynamic population:

- more than 22 nations represented in New Zealand
- each with their own unique culture, language, history, and health status
- for many families language, cost and access to care are barriers

Pacific ethnic groups in Hawke's Bay include Samoa, Cook Islands, Fiji, Tonga, Niue, Tokelau, Kiribati and Tuvalu. Samoan and Cook Island groups are the largest and make up two thirds of the total Pacific population. There is a growing trend of inter-ethnic relationships and New Zealand born Pacific populations.

Acknowledge [The FonaFale Model](#) (Pacific model of health) when working with Pacific people and families.

General guidelines when working with Pacific people and families (information developed by Central PHO, Manawatu):

- [Cultural protocols and greetings](#)
- [Building relationships](#) with your Pacific people
- [Involving family support and religion](#) during assessments and in the hospital
- [Home visits](#)

Hawke's Bay-based resources:

- [HBDHB interpreting service website](#) or phone 06 8788 109 ext.. 5805 (no charge for the hospital; charges may apply for community-based translations) or contact coordinator at interpreting@hbdhb.govt.nz
- Pacific Navigation Services Ltd Phone: 027 971 9199
- services to assist Pacific people to access healthcare ([SIA](#))
- [Improving the Health of Pacific People in Hawke's Bay](#) - Pacific Health action Plan

Ministry of Health resources:

- [Ala Mo'ui](#) Pathways to Pacific Health and wellbeing 2014-2018
- [Primary Care for Pacific people](#): a Pacific and health systems approach
- Health education resources in [Pacific languages](#) (links to a web page where you can download resources)

Last Days of Life - Adults

Medicine > Palliative Care > Palliative Care

- [Best health outcomes for Pacific Peoples: Practice implications](#)

6 Advance care planning

Quick info:

Advance Care Planning:

Advance Care Planning is a voluntary process of discussion and shared planning for future health care. It involves the person who is preparing the plan, and usually involves family/whanau and health care professionals.

Advance Care Plan:

An Advance Care Plan is the outcome of Advance Care Planning. It is formulated by the person and sets out their views about care towards the end of their life. It may also include views about medical care and a wide range of other matters. An Advance Care Plan may include an Advance Directive.

Advance Directive:

An Advance Directive is a statement a person makes about their medical care in the future and becomes effective if a person ceases to be competent to make decisions for themselves. An Advance Directive is legally binding if made in appropriate circumstances.

Competency and Advance Care Planning:

Competent people have the right to make autonomous decisions that as medical professionals we may regard as imprudent, and sometimes such decisions are a reflection of the person's longstanding personality, beliefs or lifestyle. This right is described in the Health and Disability Consumers Rights Acts.

According to ACP - A Guide for the NZ Health Care Workforce - "in the context of ACP, competency relates to an individual's ability to make a decision regarding their own health care (that is, competence at decision-making or decision-capacity). At a minimum, decision making capacity requires the ability to understand and communicate, to reason and deliberate, and the possession of a set of values".

Helpful websites:

- [The code of rights](#)
- [Advance care planning guide Ministry of Health](#)
- [Advance care planning resources](#)

7 Specialist Palliative Services

Quick info:

Criteria for referral to Cranford Hospice:

- the person has active, progressive and advanced disease
- the person has a level of need that exceeds the resources of the primary palliative care provider
- the person agrees to the referral if competent to do so (or an advocate agrees on their behalf)
- the person has New Zealand residency or has reciprocal rights, and is a resident within the HBDHB

Note: Prognostic uncertainty is not a barrier for referral. Diagnosis and prognosis does not dictate referral acceptance or level of input, rather this is needs based, examples include:

- uncontrolled or complicated symptoms
- specialised nursing requirements relating to mobility, functioning or self-care
- emotional or behavioural difficulties related to illness, such as anxiety or depression
- concern or distress involving children, family or carers, physical and human environment (including home or hospital), financial, communication or learning disability
- issues around self-worth, loss of meaning and hope, suicidal behaviours, requests for euthanasia and complex decisions over the type of care, including its withholding or withdrawal

[Cranford hospice referral form](#)

[In hospital referral form](#)

[Discharge from regional hospital to other facility](#)

8 Identifying the dying person

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Quick info:

When a person's condition deteriorates significantly, and it is thought they may die soon, they must be assessed by a health professional who is competent to judge whether:

- the change is potentially reversible and the 'goals of treatment' suggest further investigation or a new intervention is appropriate and/or wanted by the person

or if

- the person is likely to die and the 'goals of treatment' suggest further investigation or a new intervention is NOT appropriate and/or NOT wanted by the person

Factors that may indicate that the phase of dying has commenced includes 2 - 3 of the following signs or symptoms:

- profound weakness
- reduced intake food and fluids
- difficulty swallowing/taking oral medication
- drowsy or reduced cognition - semi conscious with lapses into unconsciousness
- bed bound after progressive decline over days to weeks
- peripheral shutdown

Note: There will always be a degree of uncertainty over the timing of a person's death (and there may be a chance that their condition will improve), but this should not preclude anticipatory discussions and the implementation of holistic person-centred care.

Refer to LINK:

[Identifying the Dying Patient Flowchart](#)

[Health Quality & Safety Commission. \(2016\). The deteriorating adult patient: Current practice and emerging themes](#)

Brochures from Cranford:

[What to expect when someone is dying](#)

[What to expect when someone is dying - the process](#)

9 Communicating the diagnosis of dying

Quick info:

Ensure all discussions and decisions are in accordance with the person's needs and wishes:

- assess the person's understanding that they are entering the last days of life
- provide desired level of information regarding their changing condition
- assess the family/whanau understanding
- notify other relevant health professionals as required
- refer to any previously documented advance care decisions or preferences

Refer to Advance Care Planning box above.

[Breaking bad news flowchart](#)

[Adaptation of Spikes](#)

[Palliative circle of support](#)

[Contact numbers](#)

10 Level of Understanding and Engagement

Quick info:

Assess the person/family's level of understanding and engagement in medical care.

Ask the person/family/whanau about:

- their understanding of their symptoms or problem at the moment
- their understanding of what has to happen next

Consider:

- familiarity with medical terminology and knowledge
- language of origin/preferred language

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- hearing impairment
- cultural background and belief systems
- anxiety/stress

Address any issues regarding understanding and engagement.

Consider barriers to effective care:

- whanau, family and social network dynamics:
 - whanau support, family history
 - family obligations including dependents
 - work responsibilities
 - whanau, hapu and iwi obligations
 - community engagement and obligations or responsibilities
- locality and geographical access to services
- socio-economic factors including source of income

[Tikanga Guidelines](#)

Best health outcomes for Pacific Peoples: Practice implications

Refer to Advance Care Planning box above

12 Caring for the dying person and Last Days of Life Care Plan

Quick info:

Care for the person in their last days of life is person-centred and holistic.

The delivery of care is to be:

- individualised and respectful of any cultural, spiritual, religious and family issues
- acknowledges the following factors important to the person and family/whanau ([Te Whare Tapa Wha](#)):
 - physical care (te taha tinana)
 - religious/spiritual (te taha wairua)
 - psychological (te taha hinengaro)
 - family/whanau (te taha whanau)

The Last Days of Life Care Plan comprises of four components incorporating the principle of [Te Whare Tapa Wha](#):

- baseline assessment
- plan of care
- ongoing monitoring
- care after death

The goals of treatment and care must be discussed and agreed with the dying person/family/whanau, involving those identified as important to them, and the multidisciplinary team (MDT).

If a person who is dying lacks capacity:

- consult and discuss with the EPOA (health and welfare) if available
- have the discussion with the people who are supporting the person as appropriate

The Last Days of Life Care Plan should be:

- reviewed as circumstances change, (including changing preferences of the dying person)
- be documented so that consistent information about the person's needs and wishes is available and shared with those involved in the person's care and available at the time this information is needed

Refer to LINK Last Days of Life care Plan

[W.H.A.N.A.U Personalising Care at the end of life](#)

[Identifying the dying person](#)

[Last days of life care plan instructions](#)

[Last days of life contacts](#)

[Last days of life initial assessment page 1 of 2](#)

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[Last days of life initial assessment page 2 of 2](#)

[Last days of life planning care](#)

[Last days of life care plan 1](#)

[Last days of life care plan 2](#)

References:

Te ara Whakapiri - Principles and guidance for the last days of life. MOH 2015

13 Symptom management & medication formulary

Quick info:

Regular assessment, documentation, and management of any symptoms is vital.

All medications, including anticipatory medications, must be:

- targeted at specific symptoms
- have a clinical rationale for the starting dose
- be regularly reviewed and adjusted as needed for effect

Last days of Life prescribing guidelines for the following symptoms are available:

- [pain](#)
- [agitation](#)
- [respiratory tract secretions](#)
- [nausea and vomiting](#)
- [dyspnoea](#)

The following symptoms should be considered and guidance and advice sought where necessary:

- [micturition difficulties](#)
- [bowel care](#)
- mouth care

NB: the reason for any intervention, including the use of a continuous infusion pump (syringe driver):

- must be explained to the person and to those important to the dying person
- the likely side effects, especially those that may make the person sleepy, must be discussed with the dying person (and to those important to them if the person wishes) to enable them to make informed decisions

Refer to:

[Cranford Hospice clinical procedure syringe driver T34](#)

[HBDHB T34 syringe pump infusion device guidelines](#)

[HBDHB T34 subcutaneous infusion prescribing in palliative care](#)

14 Physical Care (Te Taha Tinana)

Quick info:

These are measures that may address the person's symptoms and the effects that these have, considerations include:

- reviewing current medications and discontinuing any that are non-essential
- converting necessary medications to the subcutaneous route and anticipatory signing
- considering the use of a continuous infusion pump (syringe driver) as appropriate
- inappropriate interventions discontinued e.g. blood tests, routine observations, blood glucose monitoring, oxygen therapy
- the need for artificial hydration/nutrition
- elimination needs - address constipation where necessary, consider Indwelling catheter (IDC) or continence products as identified as these can contribute to restlessness and other symptoms
- consider non-pharmacological measures for the person that may help relieve physical symptoms for that individual, including:
 - repositioning patient for comfort – consider use of pressure relieving mattress
 - regular mouthcare

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- warmth
- if person has a implantable cardioverter-defibrillator (ICD) or pacemaker, a relevant care plan should be developed (or reviewed)

15 Psychological (Te Taha Hinengaro)

Quick info:

Consider the effects upon the person's mood, anxiety, and personal relationships with equal focus on the effects upon families, whanau, carers, and loved ones. It requires complete dignity and respect.

Considerations include:

- assessing the person's and their family's/whanau or carers' ability to understand and recognise that the person is dying and the measures that are being taken to ensure their comfort
- recognising the health needs and social support of the family/whanau and carers
- recognising and acknowledging feelings of fear, anxiety, anger, depression or a sense of 'unfinished business' that the person and/or family/whanau may have. Anxiety is often present as a symptom (in the absence of anxiety disorder)
- ensuring that the person and family/whanau or carers continue to be kept aware of the current situation
- the use of non-verbal communication techniques (e.g. touch) as appropriate
- supporting the family/whanau to create an environment that is most culturally familiar to the person. This may include:
 - people present
 - pets
 - bedding
 - taonga
 - photos etc
- consider preferences for place of care and death. Where possible facilitate transfer to that place

16 Religious/Spiritual (Te Taha Wairua)

Quick info:

Consider any religious/spiritual beliefs that the person may already have, or the need to search for meaning and understanding of their life and circumstances. The person may have concerns for themselves or for others left behind.

Considerations include:

- being prepared to discuss religious and spiritual issues, respecting the person's need for:
 - dignity
 - hope
 - feelings of self-worth and identity
 - meaning and purpose of life
- offering the support of religious leaders/chaplaincy team if appropriate/available
- identifying religious traditions and ensuring that any required support is in place
- recognising that the individual may have spiritual needs, even if he/she is not religious
- identifying any cultural needs either now at the time of impending death or after death, e.g. provision for religious ceremonies, washing
- continuing to respectfully acknowledge, and being prepared to discuss, the person's and family's/whanau spiritual needs as death approaches
- "For Maori, death and dying it is deeply imbued with cultural significance, and it is not uncommon even for Maori who are otherwise relatively unobservant to follow very traditional practices when they or loved ones are near death" [1]

[Spiritual Care Assessment tool \(FICA\)](#)

[For supplies and brochures,](#)

Contact:

- Funeral Directors Association of NZ (Inc)
- PO Box 10888 Wellington 6143

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- email: info@fdanz.org.nz
- website: www.funeralsnewzealand.co.nz

Reference:

- Ministry of Health. 2014. Palliative Care and Maori from a Health Literacy Perspective. Wellington: Ministry of Health [1]

17 Family/Whanau (Te Taha Whanau)

Quick info:

The needs of family and others identified as important to the dying person should be actively explored, respected, and met as far as possible.

Family and others important to the dying person (including carers):

- have their own needs which they, and others, can overlook at this time of distress
- it is important to provide opportunities for families and care givers to express and explore their individual needs – they may have specific concerns such as:
 - fear about the person dying
 - anxiety about an emergency occurring, i.e. what constitutes an emergency and how to deal with it
 - feelings of inadequacy with regard to caring for the person at home (if at home), e.g. lack of knowledge about how to make the person comfortable or appropriate lifting techniques. Remember that this feeling can also occur if health professionals 'take-over' the care
 - suppression of their true emotions in order to protect the person they are caring for
 - financial worries
 - altered role and lifestyle
 - what to do when the person dies
- where they have particular needs for support or information, these must be met as far as possible
- although it is not always possible to meet the needs or wishes of all family members, listening and acknowledging these can help

18 Ongoing assessment

Quick info:

The person must be monitored a minimum of 4 hourly and more often if necessary to:

- check that the plan of care remains appropriate
- respond to changes in the person's condition, needs and preferences

Where a person's condition/goal changes, this should be a 'trigger' for making decisions to change care and treatment (or review the goal again later)

[Ongoing assessment outcomes](#)

[Ongoing assessment outcomes 2](#)

[Progress notes](#)

[Progress notes 2](#)

19 Verification of death

Quick info:

Verify death:

- death should be regarded as the irreversible loss of the capacity for consciousness, combined with irreversible loss of the capacity to breathe
- in the community, the body must not be moved until death has been verified

Recording death:

- time and date of death

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- time death certified
- who was present
- presence of implantable devices – arrangements are needed to inactivate these and to organise removal if not made previously. Funeral director needs to be informed

[Care after death](#)

20 Care of the body

Quick info:

The body of the deceased should be cared for in a culturally sensitive and dignified manner.

Considerations include:

- some relatives may wish to assist with the personal care according to individual wishes, religious, or cultural requirements
- local infection control policies should be followed where the person has a known or suspected infection

[Care after death](#)

21 Notification

Quick info:

When death occurs, the relevant professional, family/whanau member, or carer should have the necessary guidance on:

- what to do next
- whom to contact
- all relevant contact numbers
- what will happen next

Death should be verified according to organisation policy and procedure.

The persons death:

- should be communicated across all appropriate healthcare teams
- family and carers should receive relevant support and written information about:
 - grief, loss, and bereavement
 - legal tasks, such as collection of the death certificate and registration of death

[Last days of life - care after death](#)

[For supplies and brochures,](#)

Contact:

- Funeral Directors Association of NZ (Inc)
- PO Box 10888 Wellington 6143
- email: info@fdanz.org.nz
- website: www.funeralsnewzealand.co.nz

22 Certify the death

Quick info:

It is usual practice for a doctor who has been involved in the deceased person's care, and has seen them in the past two weeks, to examine the body and complete the death certificate and cremation form.

For deaths in the Regional Hospital:

- the information written on the death certificate is the responsibility of the consultant; therefore if the certificate is completed by a junior doctor, this needs to have been discussed with a senior doctor first

23 Arrange transfer of the person

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Transfer of the person:

- once a death certificate has been issued, the funeral director can be contacted and the person transported to the funeral home
- transfer will vary according to Organisation Policy
- families and carers may wish to take the responsibility for caring for the person and/or make their own funeral arrangements.

For local Funeral Homes:

[For supplies and brochures,](#)

Contact:

- Funeral Directors Association of NZ (Inc)
- PO Box 10888 Wellington 6143
- email: info@fdanz.org.nz
- website: www.funeralsnewzealand.co.nz

Provenance Certificate Last days of Life - Adults

Overview

This document describes the provenance of Hawke's Bay's District Health Board's Last days of Life - Adults Pathway. It was developed in September 2016 and first published in September 2016. A review of the Pathway is due in March 2017.

The purpose of implementing Last Days of Life pathway locally is to meet the needs of health care professionals, the person and their carers by providing an up-to-date, localised, evidence-based overview of the standard of care that can be offered following an assessment or diagnosis.

Pathways are significant enablers for integrating health care across primary and secondary settings, accruing multiple stated benefits including access to the same quality care within the same timeframes, irrespective of their ethnicity, gender, locality or socio-economic status reduced inequities, faster referrals to definitive care, improved health outcomes and lowered costs.

To cite this pathway, use the following format:

Map of Medicine – Hawke's Bay View / Palliative Care / Last days of Life - Adults

Editorial methodology

This Pathway was based on high quality information and known Best Practice guidelines from New Zealand and around the world including Map of Medicine editorial methodology. It was developed by individuals with front-line clinical experience (see contributors section of this document) and has undergone consultation to gain feedback and input from the wider clinical community.

Map of Medicine Pathways are constantly updated in response to new evidence. Continuous evidence searching means that Pathways can be updated rapidly in response to any change in the information landscape. Indexed and grey literature is monitored for new evidence, and feedback is collected from users year-round. The information is triaged so that important changes to the information landscape are incorporated into the Pathways through the quarterly publication cycle.

An update to this Pathway is scheduled for 6 months after first publication. However, feedback is welcomed at any time, with important updates added at the earliest opportunity within the Map of Medicine publishing schedule.

References

This Pathway has been developed according to the Map of Medicine editorial methodology. Its content is based on high-quality guidelines and practice-based knowledge provided by contributors with front-line clinical experience. Feedback on this Pathway was received from stakeholders during a consultation process.

1	National End of Life Programme. The route to success in end of life care - achieving quality in acute hospitals. London: Department of Health (DH); 2010
2	Leadership Alliance for the Care of Dying People (LACDP). One chance to get it right: improving people's experience of care in the last few days and hours of life. London: LACDP; June, 2014
3	Ministry of Health. 2014. Palliative Care and Maori from a Health Literacy Perspective. Wellington: Ministry of Health
4	National Institute for Health and Clinical Excellence (NICE). Improving supportive and palliative care for adults with cancer – the manual. London: NICE; 2004

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- Wendy Wasson, Editor, HBDHB
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Disclaimers

Clinical Pathways Steering Group, Hawke's Bay DHB and Health Hawke's Bay – Te Oranga Hawke's Bay.

It is not the function of the Clinical Pathways Steering Group, Hawke's Bay DHB and Health Hawke's Bay – Te Oranga Hawke's Bay to substitute for the role of the clinician, but to support the clinician in enabling access to know-how and knowledge. Users of the Map of Medicine are therefore urged to use their own professional judgement to ensure that the patient receives the best possible care.

Whilst reasonable efforts have been made to ensure the accuracy of the information on this online clinical knowledge resource, we cannot guarantee its correctness and completeness. The information on the Map of Medicine is subject to change and we cannot guarantee that it is up-to-date.