

Palliation of Patients at the End of Life in the Emergency Department – Guideline

Category:	Guideline
Summary:	This guideline outlines best practices for providing palliative and end-of-life care in the Emergency Department (ED) at Oxford University Hospitals NHS Foundation Trust. It emphasises the importance of compassionate, symptom-focused care for patients nearing the end of life, involving families in decision-making, and ensuring clear communication and documentation. Key areas include recognising end-of-life trajectories, managing common symptoms, addressing emotional and environmental needs, and supporting organ and tissue donation where appropriate. The guideline aims to ensure dignified care in the often high-pressure ED setting, with a focus on collaboration across teams and respecting patient and family wishes.
Equality Impact Assessed:	May 2025
Valid From:	01/02/2026
Date of Next Review:	3 years from the approval date
Approval Date:	01/12/25
Distribution:	Emergency Department, acute medical team and intensive care staff
Related Documents:	<u>Anticipatory 'Just in case' Prescribing Guideline for Adults</u> Tissue Donation in ED Guideline OUH ReSPECT policy
Author(s):	Manjit S Riyat, Edward Norris-Cervetto, Jon Bailey
Further Information:	
This Document replaces:	New Document

Lead Director: Manjit Riyat – ST8 ICM/EM

Issue Date: 01/12/2025

This document is uncontrolled once printed.

It is the responsibility of all users to this document to ensure that the correct and most current version is being used.

This document contains many hyperlinks to other related documents.

All users must check these documents are in date and have been ratified appropriately prior to use.

Document History

Use this table to record the revisions made to the approved policy and record document history.

Date of revision	Version number	Author	Reason for review or update
01/02/26	1.1	Manjit S Riyat, Edward Norris- Cervetto, Jon Bailey	New Guideline

Consultation Schedule

Use this table to evidence your involvement of staff and key stakeholders, where appropriate, in the development and review of documents.

Who? Individuals or Committees	Rationale and/or Method of Involvement
Dr Neil Dawson	Support for principle of guideline, ensure buy in from ED divisional lead.
Dr Rebecca Whittaker	ITU and Neuro ITU consultant
Dr Daniel Wood	CLOD for Neuro ITU
Dr James Dearman	Lead for tissue donation for Emergency Medicine
Dr Graham Barker	CLOD for OCC
Dr Victoria Hedges/Nicola Taylor/Amelia Sayce	Palliative Care Team involvement
Catrina Fleming	Lead Resuscitation Practitioner

Endorsement

Use this table to list relevant Divisional and/Directorate leads who have endorsed the policy/procedural document.

Endorsee Job Title
Dr Neil Dawson – Divisional Director Emergency Medicine,
Dr Rebecca Whittaker - ITU and Neuro ITU consultant
Dr Daniel Wood - CLOD for Neuro ITU
Dr James Dearman Tissue donation lead for Emergency Medicine
Dr Victoria Hedges - Consultant in Palliative Medicine and end of life care lead for the trust

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Who should read this document?

This guideline is intended for use by clinical staff within the Emergency Departments across Oxford University Hospitals NHS Foundation Trust (OUH):

- Emergency Department consultants, registrars, and resident doctors
- Advanced clinical practitioners and nursing staff
- Intensive Care and Acute Medicine teams
- Thames Valley Air Ambulance clinicians
- Chaplaincy, bereavement and palliative care teams

Key Messages

1. End of life (EOL) care should be regarded as a core emergency medicine skill [RCEM, 2020].
2. Patients recognised as dying in the ED should receive compassionate, holistic and symptom-led care.
3. Escalation decisions should be made collaboratively between ED, ICU, the patient (if possible) and/or their family.
4. Clear documentation of decisions around resuscitation, escalation, and goals of care is essential.
5. When death is expected imminently, patients should be cared for in a side room in the ED where possible.

Background/Scope

The emergency department (ED) often becomes the place where dying is recognised, and decisions about escalation or end of life care are made. While emergency care traditionally centres around life-saving interventions, it is equally vital to manage symptoms and provide dignified end of life care. This is supported by the Royal College of Emergency Medicine, who affirm that emergency palliative care is a necessary core skill in emergency medicine practice [RCEM Toolkit, 2020].

Approximately 10% of patients admitted via ED may die during their hospital stay, with even higher rates in frail or elderly populations [Clark et al., 2014]. The need to act swiftly, in emotionally charged environments, further underscores the importance of structured palliative care guidance for ED settings.

Aim

To provide a clear, evidence-based framework for the delivery of palliative and end of life care in the Emergency Department at OUH, ensuring that patients receive compassionate, dignified and person-centred care.

Guideline

1.1 Recognising End of Life Trajectories

Common trajectories include:

- Sudden catastrophic events (e.g. subarachnoid haemorrhage)
- Deterioration in the context of incurable illness (e.g. metastatic cancer)
- Deterioration in the context of pre-existing organ failure (e.g. advanced COPD)
- Frailty and progressive decline (e.g. dementia, repeated infections)

Indicators such as refractory bradycardia, cyanosis, unresponsiveness or respiratory secretions may suggest imminent death. Tools like the Clinical Frailty Score, Amber Care Bundle and local anticipatory care plans should guide assessments.

1.2 Communication and Advance Planning [also see End of Life Care PowerPlan on EPR]

Use clear and empathetic language. Questions such as:

- "What is most important to you right now?"
- "Do you know if [patient] had any thoughts about treatments or being in hospital?"

Avoid euphemisms. Phrases such as "You are very unwell, and I'm concerned you may not survive this illness" "I am concerned that you may be dying" provide clarity.

Enquiring about thoughts on treatments is not an obligation to provide said treatment, any treatment offered is a clinical decision, but patient wishes may help inform the decision-making process.

Check for existing Advance Care Plans, DNACPR forms, ReSPECT, advance decisions and LPAs.

1.3 Symptom Control

Common symptoms and management (use palliative care/end of life care prescribing PowerPlan on EPR for PRN subcutaneous medication), namely:

- Pain: morphine 2.5mg hourly if needed (oxycodone 1.25mg s/c as an alternative or in renal failure)
- Breathlessness: Fan (non-infectious cases), morphine 2.5 mg hourly if needed (oxycodone 1.25mg as an alternative or in renal failure)
- Agitation: midazolam 2.5mg hourly if needed or haloperidol 1 mg every 2 hours if needed.
- Secretions: hyoscine butylbromide 20mg
- Nausea: haloperidol 0.5mg or metoclopramide 10 mg.

Anticipatory prescribing and nursing access to medications is essential.

1.4 Environmental and Emotional Considerations

- Prioritise side rooms where available.
- Discontinue monitoring, tests, interventions.
- Offer basic mouth care and repositioning.
- Offer with chaplaincy and after death, liaise with bereavement services.
- Offer keepsakes such as handprints and hair locks as outlined in the bereavement box.

1.5 Family Involvement and Visiting

- Key visitors should be permitted and supported, even out-of-hours.
- Visitors should be offered PPE & supported through infection control measures.
- Provide clear communication on what to expect as the patient nears death. Provide them with the Trust leaflet 'What to expect when someone dies in hospital.'

1.6 Documentation and Escalation Planning

- Clearly document any ceiling of medical interventions discussions, DNACPR recommendation , and patient/family input; these are collectively recorded in ReSPECT.

- Early ICU (for decisions about extubation) and palliative care team involvement is encouraged if appropriate.
- Preferred place of death should be discussed and, where feasible, facilitated.

1.7 Organ and Tissue Donation

- Organ and tissue donation are distinct.
- Record discussions clearly and sensitively.

Organ donation (for intubated patients):

- OUH aims to discuss 100% of patients for end of life care and extubation with Specialist Nurse for Organ Donation (SNOD).
- To liaise with a SNOD call 0300 020 3040
- A lack of available intensive care bed does not preclude organ donation. Patients suitable for donation can stay in the Emergency Department until a bed arises and be classed as a 'clinical breach': organ donation saves lives.'

Tissue Donation (see specific ED guideline)

- Patient wishes should be explored regarding Tissue Donation. Holistic conversations should occur with patients at the end of life or with their families after death. Tissue donation referral should occur as soon as possible after death and retrieval of tissues can occur up to 24 hours after asystole.
- Many patients will be eligible donors.
- Absolute contraindications include blood-borne malignancies, blood-borne viruses and neurodegenerative conditions (including dementia).
- To ask about eligibility and/or refer for Tissue Donation call National Referral Centre 0800 432 059

1.8 Legal and Ethical Considerations

- Follow Mental Capacity Act 2005 as applicable.
- Avoid assumptions; consider cultural, spiritual and communication needs.
- For sudden deaths, follow referral protocols for Coroner.

1.9 Discharge Planning and Preferred Place of Death

If discharge is safe and appropriate:

- Ensure community palliative care support is in place.
- Prescribe anticipatory medications and supply a direction to administer (link in prescribing powerplan).
 - Anticipatory 'Just in case' Prescribing Guideline for Adults
- Communicate with GP and district nursing teams.
- Involve family and confirm transport availability.

2.1 Patients Intubated in the Pre-hospital setting

Background:

In the pre-hospital care phase, the emphasis is on resuscitation and safe transport to hospital, and the full clinical picture may not be clear at the time that immediate lifesaving interventions are required. It is therefore inevitable that some patients will receive treatments that with a more comprehensive evaluation would not be felt appropriate, and that some patients may later be assessed as unsuitable for critical care admission.

Whilst the opinion of the prehospital team should be considered, clinical responsibility for patient care in hospital is unambiguously the responsibility of the hospital teams.

The presence of an endotracheal tube on arrival to the emergency department is not in isolation an indication for admission to critical care and a holistic evaluation of the patient's clinical case should be undertaken prior to admission to such a setting.

This process is no different to that of a patient who is not intubated. **Where neuroprognostication or active treatment is felt appropriate, admission to critical care should proceed as normal; this includes patients with perceived devastating brain injury as the primary pathology – for whom the advice is a period of neuroprognostication.**

Patients may be intubated in the pre-hospital setting both with and without drugs, which may influence the ability to extubate. Use of drugs in the prehospital setting does not by default preclude extubation, but appropriate consideration of anaesthetic agents and neuromuscular blockade, in terms both of dosages and timing, should be considered.

Whenever withdrawal of life sustaining treatment is planned to occur in a mechanically ventilated patient in the ED, a referral should be made to the SNOD for consideration of potential donation regardless of age or co-morbidity.

Where a patient does not have survivable pathology and there is no prospect of organ donation, extubation should take place in the emergency department.

Extubation should be performed by an individual who is competent to do so, which may be the ED medical or nursing staff, or the ITU medical team.

Whilst the principles for palliative extubation apply to both adults and children, the threshold for palliation in children is usually higher and it is unlikely that this policy will be used in the paediatric population.

Guidance:

- Emergency medicine consultant cover is provided in the John Radcliffe ED 24-hours per day, and therefore an emergency medicine consultant must always be involved in the assessment and decision to move to end-of-life care in the ED.
- Patients may present intubated to the Horton ED, but this is rare. Where this does happen, admission to ITU will necessitate a transfer to John Radcliffe Hospital, if the admission to ITU appears inappropriate patients should be reviewed in the ED to allow consideration of options.
- Rapid, early input from Emergency Medicine, ITU and relevant specialties as dictated by the presenting pathology is essential to reach an early consensus on ceilings of medical treatments for the patient and any decision to extubate and manage end of life care.
- Treatment escalation decisions must be made collaboratively, involving the family or those close to the patient where possible.
- **Caution is advised for patients presenting with severe brain injury perceived to be devastating (DBI). Early prognostication can be unreliable, and a period of physiological stabilisation and observation is recommended to support more informed decision-making. During this time, patients who are intubated will typically require admission to critical care.** Exceptions may be made when the burden of co-morbidities is such that continued organ support would offer no overall benefit, regardless of the potential for neurological recovery.
- Where a patient is extubated in a clinical cubicle, priority should be given to moving to an appropriate side room when clinical need to maintain resource availability is high. This will be a clinical decision for the ED and operational teams.
- Admission to critical care solely for extubation is an inefficient use of resources and should be considered a last resort.
- If death is not imminent, care should be transferred to acute general medicine for ongoing management & palliative care should referral be made.
- The Hospital Palliative Care Team (HPCT) can be contacted for assistance or advice on Ext 21741 (08:30-18:00 including weekends and bank holidays). Urgent advice after 18:00 is available from the Palliative Medicine doctor on-call (contact via Switchboard)
- Note that discussions around palliation and ceilings of treatment should be made by the emergency medicine team, **not** be deferred to the medical team.
- These cases require sensitive communication, acknowledging the complexity and pressure of the pre-hospital environment.

Summary

Providing excellent end-of-life care in the ED is a fundamental aspect of patient care and professional responsibility. Recognising dying, facilitating clear communication, controlling symptoms, and involving the right multidisciplinary teams ensures that patients can die with dignity — even within the often-chaotic ED environment.

Review

1. This policy will be reviewed every 3 years, as set out in the [Policy for the Development and Implementation of Procedural Documents](#).
2. *N.B. Policies may need to be revised before this date, particularly if national guidance or local arrangements change, where implementation is unsuccessful or where audits necessitate a policy review.*
3. If the approving committee of the policy has delegated the authority to approve supporting documents to another group, this should be documented here. E.g. The Trust Management Executive has delegated authority to the Health & Safety Committee for the approval of any further supporting or associated documents.

References

1. Royal College of Emergency Medicine (2020). *End of Life Care Toolkit*. RCEM, London.
2. Scottish Academy of Medical Royal Colleges (2020). *Statement on Patients and Families at End of Life*. Scottish Academy of Medical Royal Colleges, Edinburgh.
3. Clark, D., Armstrong, M., Allan, A., Graham, F., Carnon, A. and Isles, C. (2014). Imminence of death among hospital inpatients: prevalent cohort study. *Palliative Medicine*, 28(6), pp. 474–479.
4. National Institute for Health and Care Excellence (2015). *Care of dying adults in the last days of life (NICE Guideline NG31)*. NICE, London.
5. Faull, C. and Nyatanga, B. (2005). *Handbook of Palliative Care*. Blackwell Publishing, Oxford.
6. Royal College of Emergency Medicine (2020). *RED-MAP Communication Framework*. RCEM, London.
7. NHS Education for Scotland (2020). *Psychological First Aid Toolkit*. NHS Education for Scotland, Edinburgh.
8. NHS Blood and Transplant, Royal College of Emergency Medicine and Faculty of Intensive Care Medicine (2016). *Organ Donation in Emergency Medicine: Guidance in End of Life Care for Emergency Medicine*. NHS Blood and Transplant, London.
9. Faculty of Intensive Care Medicine. (2018). *Management of perceived devastating brain injury after hospital admission: A consensus statement*. <https://ficm.ac.uk/sites/ficm/files/documents/2021-10/Management%20of%20Perceived%20Devastating%20Brain%20Injury%20After%20Hospital%20Admission.pdf>

Appendix 1: Responsibilities

The Chief Executive has overall responsibility for ensuring the provision of safe and effective care within the Trust, including palliative and end-of-life care in the Emergency Department

- 1.1. The Medical Director has delegated authority for the implementation and clinical governance of this guideline.
- 1.2. The Lead Consultant for Emergency Medicine is responsible for ensuring that ED staff are aware of and adhere to this guideline. All Managers are responsible for:
- 1.3. The Matron for the Emergency Department is responsible for ensuring adequate resources and training are available for nursing staff to deliver effective palliative and end-of-life care.
- 1.4. Emergency Department Consultants, Registrars, Resident Doctors and Advanced Clinical Practitioners are responsible for:
 - 1.4.1.1. Recognising patients who are in the end-of-life trajectory
 - 1.4.1.2. Initiating appropriate palliative care interventions as outlined in this guideline
 - 1.4.1.3. Communicating sensitively with patients and families
 - 1.4.1.4. Documenting decisions and care plans clearly
- 1.5. Emergency Department Advanced Clinical Practitioners and Nursing Staff are responsible for
 - 1.5.1.1. Providing compassionate and dignified care to patients
 - 1.5.1.2. Administering medications for symptom control
 - 1.5.1.3. Supporting families and carers
 - 1.5.1.4. Liaising with other services (e.g. chaplaincy and bereavement services)
- 1.6. The trust palliative care team will provide specialist advice and support to the ED as needed.

Appendix 2: Definitions

- **DNACPR:** Do Not Attempt Cardiopulmonary Resuscitation
- **EOL:** End of Life
- **ICU:** Intensive Care Unit
- **LPA:** Lasting Power of Attorney
- **OUH:** Oxford University Hospitals
- **PPE:** Personal Protective Equipment
- **ReSPECT:** Recommended Summary Plan for Emergency Care and Treatment
- **SNOD:** Specialist Nurse for Organ Donation
- **TVAA:** Thames Valley Air Ambulance
- **HCID –** High consequence infectious disease
- **Palliative Care:** Care aimed at improving the quality of life of patients and those close to patients facing problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.
- **End of Life Care:** Care of a person who is approaching death, which supports them to live as well as possible until they die, and includes care after death.
- **Advance Decision:** A decision made by a person with capacity about their future healthcare treatment, which will come into effect if they lose capacity."

Appendix 3: Education and Training

For policies which include mandatory training, include a standard statement that:

- 1.1. Training required to fulfil this policy will be provided in accordance with the Trust's Training Needs Analysis. Management and monitoring of training will be in accordance with the Trust's Learning and Development Policy. This information can be accessed via [the Practice Development and Education pages on the Trust intranet](#).
- 1.2. There is no mandatory training associated with this policy. Ad hoc training sessions based on an individual's training needs will be defined within their annual appraisal or job plan
- 1.3. Training on palliative and end-of-life care in the ED will be provided to all relevant staff in accordance with the Trust's policy. This will include:
 - Recognition of patients in the end-of-life trajectory.
 - Symptom management.
 - Communication skills for difficult conversations.
 - Legal and ethical considerations (including Mental Capacity Act and DNACPR).
 - Cultural sensitivity and awareness.
- 1.4 Management and monitoring of training will be in accordance with the Trust's Learning and Development Policy. This information can be accessed on the Trust intranet.
- 1.5 Ad hoc training sessions and updates will be provided as needed, based on individual staff training needs identified through annual appraisal and supervision.

Appendix 4: Monitoring Compliance

Compliance with the document will be monitored in the following ways.

What is being monitored:	How is it monitored:	By who, and when:	Minimum standard	Reporting to:
<i>Timely recognition of patients in the end-of-life trajectory</i>	<i>Retrospective audit of patient records</i>	<i>ED Audit Lead, annually</i>	<i>90% of eligible patients identified within 4 hours of arrival</i>	<i>ED Clinical Governance Meeting</i>
<i>Appropriate symptom management</i>	<i>Audit of medication administration records</i>	<i>ED Pharmacy Lead, annually</i>	<i> 95% of patients with documented symptoms receive timely and appropriate medication</i>	<i>ED Clinical Governance Meeting</i>
<i>Evidence of communication with patient/family</i>	<i>Review of patient notes for documented discussions</i>	<i>ED Clinical Governance Lead, annually</i>	<i>90% of records show evidence of communication regarding end-of-life care</i>	<i>ED Clinical Governance Meeting</i>
<i>Adherence to DNACPR/ReSPECT decisions</i>	<i>Audit of patient records and escalation plans</i>	<i>ED Clinical Governance Lead, annually</i>	<i>100% adherence to documented DNACPR/ReSPECT decisions</i>	<i>ED Morbidity and Mortality Meeting</i>
<i>Availability of private room</i>	<i>Audit of room allocation records</i>	<i>ED Matron, 6 monthly</i>	<i>80% of patients requiring a private room receive one</i>	<i>ED Morbidity and Mortality Meeting</i>

Appendix 5: Equality Impact Assessment

Equality Impact Assessment Template

1. Information about the policy, service or function

What is being assessed	New Guideline
Job title of staff member completing assessment	Dr Manjit S Riyat – ST8 Emergency Medicine/Intensive Care Medicine
Name of policy / service / function:	Palliation of Patients in the emergency department
Details about the policy / service / function	This guideline outlines best practices for providing palliative and end-of-life care in the Emergency Department at Oxford University Hospitals NHS Foundation Trust. It emphasizes the importance of compassionate, symptom-focused care for patients nearing the end of life, involving families in decision-making, and ensuring clear communication and documentation. Key areas include recognising end-of-life trajectories, managing common symptoms, addressing emotional and environmental needs, and supporting organ donation where appropriate. The guideline aims to ensure dignified care in the often high-pressure ED setting, with a focus on collaboration across teams and respecting patient and family wishes
Is this document compliant with the Web Content Accessibility Guidelines?	Yes
Review Date	July 2028
Date assessment completed	07/05/2025
Signature of staff member completing assessment	Digitally Signed by Dr Manjit S Riyat
Signature of staff member approving assessment	

2.

2. Screening Stage

Who benefits from this policy, service or function? Who is the target audience?

- Patients
- Family / Carers

Does the policy, service or function involve direct engagement with the target audience?

Yes - *continue with full equality impact assessment*

End of life care in the Emergency Department

Version 1.0. – December 2025

3. Research Stage

Impact Assessment

Characteristic	Positive Impact	Negative Impact	Neutral Impact	Not enough information	Reasoning
Sex and Gender Re-assignment – men (including trans men), women (including trans women) and non-binary people.			Y		
Race - Asian or Asian British; Black or Black British; Mixed Race; White British; White Other; and Other		Y	Y		Communicat different ethn communicati
Disability - disabled people and carers			Y		
Age			Y		
Sexual Orientation			Y		
Religion or Belief			Y		
Pregnancy and Maternity				Y	Not likely to l guideline
Marriage or Civil Partnership			Y		
Other Groups / Characteristics - for example, homeless people, sex workers, rural isolation.			Y		

4. Summary stage

Outcome Measures

The primary outcome of this guideline is to ensure that all patients, regardless of their protected characteristics, receive equitable access to compassionate and dignified palliative and end-of-life care within the Emergency Department. Key measures include:

- Timely recognition of patients in the end-of-life trajectory across all age groups, ethnicities, and those with disabilities.
- Effective symptom management (pain, breathlessness, agitation, etc.) for all patients, recognising potential variations in needs based on cultural beliefs or disabilities.
- Clear communication and involvement of families/carers, adapted to meet diverse communication needs (e.g., language, disability).
- Respect for advance care plans and wishes, ensuring these are understood and followed for all patients, including those lacking capacity.
- Equitable access to private rooms and support services (e.g., chaplaincy, bereavement services), taking into account religious and cultural needs.
- We are assured that these outcomes will be achieved equitably for all protected groups. Ongoing monitoring (see Appendix 4) will track any disparities in access or outcomes, and actions will be taken to address any identified inequities.

Positive Impact

This guideline has the potential to positively impact several protected groups:

- **Older people:** The guideline promotes proactive recognition of frailty and decline, ensuring their specific needs in end-of-life care are met.
- **People with disabilities:** The emphasis on clear communication and individualised care planning will benefit patients with communication or cognitive impairments. The guideline also advocates for reasonable adjustments (e.g., accessible information formats).
- **People from diverse ethnic and religious backgrounds:** The guideline encourages culturally sensitive communication and respect for diverse beliefs and practices surrounding death and dying.
- **Actions to increase positive impact:**
 - Develop training materials that specifically address the needs of diverse groups in the ED setting.
 - Ensure access to translation services and communication aids is readily available in the ED.
 - Establish links with community groups representing different protected characteristics to gather feedback and ensure ongoing relevance.

Unjustifiable Adverse Effects

No unjustifiable adverse effects on protected groups have been identified.

Justifiable Adverse Effects

No justifiable adverse effects on protected groups have been identified. However, potential risks that require ongoing attention include:

- **Unequal access to private rooms:** If private rooms are limited, there's a risk that some patients (and their families) may not receive the same level of privacy and dignity.
 - **Mitigating action:** Prioritise private rooms for end-of-life care and develop a clear protocol for allocating these rooms fairly.
- **Communication barriers:** In the fast-paced ED environment, there's a risk that staff may not always communicate effectively with patients with communication needs (e.g., due to disability, language differences).
 - **Mitigating action:** Provide staff training on communication strategies and ensure access to interpreters and communication aids.
- **Cultural insensitivity:** Lack of awareness of diverse cultural practices could lead to inappropriate care or distress for some patients and families.
 - **Mitigating action:** Ongoing training on cultural competence in end-of-life care.

Equality Impact Assessment Action Plan

Complete this action plan template with actions identified during the Research and Summary Stages

Identified risk	Recommended actions	Lead	Resource implications	Review date	Completion date
Unequal Access to Sideroom	Prioritisation of sideroom for end of life care (unless required for infectious/HCID case)	ED matron	Monitoring of compliance and availability	07/2028	