**Caring for the Dying Patient**

**Daily Ongoing Assessment**  Place of care: …….............................................

|  |  |
| --- | --- |
|  | Record your assessment Y (Yes) N (No) |
| Date & Time: |  |  |  |  |  |  |  |  |  |  |  |  |
| Is the patient’s pain adequately controlled? |  |  |  |  |  |  |  |  |  |  |  |  |
| Is the patient calm, and not agitated or distressed? |  |  |  |  |  |  |  |  |  |  |  |  |
| Does the patient have excessive respiratory tract secretions? |  |  |  |  |  |  |  |  |  |  |  |  |
| Does the patient have any nausea and / or vomiting? |  |  |  |  |  |  |  |  |  |  |  |  |
| Is the patient’s breathing clear and comfortable? |  |  |  |  |  |  |  |  |  |  |  |  |
| Are there any problems with the patient’s bladder or bowels? |  |  |  |  |  |  |  |  |  |  |  |  |
| Is the patient’s mouth comfortable, moist and clean? |  |  |  |  |  |  |  |  |  |  |  |  |
| Have you any concerns about the patient’s current hydration and nutritional needs? |  |  |  |  |  |  |  |  |  |  |  |  |
| Does the patient have any other symptoms? Please state:………………………………… |  |  |  |  |  |  |  |  |  |  |  |  |
| Do you have any new concerns about the patient’s skin integrity? |  |  |  |  |  |  |  |  |  |  |  |  |
| Are the patient’s personal hygiene needs being met? |  |  |  |  |  |  |  |  |  |  |  |  |
| Are the patient’s psychological needs being met? |  |  |  |  |  |  |  |  |  |  |  |  |
| Are the patient’s spiritual needs being met? |  |  |  |  |  |  |  |  |  |  |  |  |
| Is the physical environment adjusted to support the patient’s individual needs? |  |  |  |  |  |  |  |  |  |  |  |  |
| Is the wellbeing of the relative / carer being supported? |  |  |  |  |  |  |  |  |  |  |  |  |
| Are care decisions being shared with the patient and / or carer(s)? |  |  |  |  |  |  |  |  |  |  |  |  |
| **Signature of the person making the assessment** |  |  |  |  |  |  |  |  |  |  |  |  |

**If a problem is identified, ensure that the care plan is updated or a new care plan is developed.**

**Caring for the Dying Patient - Ongoing Nursing Care**

To be completed if problem(s) identified.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date & Time** | **Problem / Care plan** | **Intervention** | **Outcome** | **Signature** |
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**Ensure a care plan is written for all new problems identified.**

**Caring for the Dying Patient** - **Medical Reassessment**

Date:…………........... Time: ……… Named Consultant/GP:…………………………………….…

**Clinical Assessment, Communication and Plan**

**ASSESS**

-Patient / relative / carer concerns

-Events, changes in symptoms

-Hydration, nutrition, continence, cognitive status

-Examination: mouth, skin, presence or absence of

- Pain/nausea/distress/upper respiratory secretions/ breathlessness

**CHECK**

**-Has there been a significant deterioration or improvement in the patient’s condition?**

-Drug chart for prn use of any medications

-Are necessary PRN medications prescribed and those which the patient cannot take discontinued?

-Do the nursing staff have any concerns?

-Has spiritual care been considered?

-Needs of carers including after death

**MANAGEMENT**

-Does the current management plan need to change?

-Do any drug doses or routes require adjustment?

**DISCHARGE/ SETTING**

-Is the patient in their preferred place of care?

**ESCALATION**

-Do you need to discuss this patient with a more senior colleague?

**COMMUNICATION**

-What does this patient/carer want to know about what is happening?

-Do they have any questions or concerns?

-Have you handed over any key information to other team members?

Name of person completing assessment:

…………………………………………

Signature and Designation:

…………………………………………

**Caring for the Dying Patient – Multi-disciplinary Notes**

|  |  |  |
| --- | --- | --- |
| **Date** **and****time** | **Record any significant issues and** **communication / discussion with patient / relatives / carers** | **Signature****and****designation** |
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