**Caring for the Dying Patient - Daily Ongoing Assessment**

**Secondary Care**: Minimum 4 hourly checks **Community Care**: Minimum 3 visits in 24 hours

Date: …………..… Lead Nurse: …………………..…..… Place of care: ……......................................

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Record your assessment Y (Yes) N (No) | | | | | | | | | | | |
| 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** |  |  |  |  |  |  |  |  |  |  |  |  |

**Caring for the Dying Patient - Relative / Carers Assessment** *(Once Daily):*

|  |  |
| --- | --- |
| **Do you have any concerns with your relative/friend’s comfort?** | **Do you feel your practical needs are being met?** |
|  |  |
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| **Do you feel you are managing emotionally with the current situation?** | **Are the things important to you being considered?** |
|  |  |
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**Caring for the Dying Patient - Ongoing Nursing Care**

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

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| --- | --- | --- | --- | --- |
| **Date &Time** | **Problem/Care Plan** | **Intervention** | **Outcome** | **Signature** |
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**Caring for the Dying Patient** - **Medical Reassessment**

**Lead 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 medications prescribed and those drugs 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: ……………………Designation: …………………**

**Date:…………………………...Time:………....………………**

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