

Surname:	Forename:
Address:	D.O.B.
	Patient ID no.:
	NHS no.:

Care Plan for the Last Days of Life

Person Centred Initial Holistic Nursing Assessment

Please complete with the patient and family / carer if appropriate. For those patients unable to contribute to their care assessment, complete on their behalf. Please use this sheet as a prompt when assessing the patient and their family/carer.

<p>Physical Problems</p> <p>Do you have any problems with your comfort?</p> Pain / discomfort Breathlessness Mouth – sore / dry / painful Chest secretions Swallowing difficulties Feeling sick / being sick Constipation / diarrhoea Urinary problems – continence / incontinence Catheter care Sweats / hot / cold Skin – sores / wound / dry / itch / weeping / swelling Personal care – washing / hair care Sputum Cough Sleep Mobility Other?	<p>Social / environmental concerns</p> <p>Do you feel the needs of yourself, your family / carers are being met?</p> Support for relative / carer / friend Quiet surroundings Eating / drinking facilities Comfortable surroundings Parking facilities Worries / fears Written information Support for children Financial concerns Update on plan of care Other?
<p>Emotional wellbeing</p> <p>Do any of these words describe how you feel?</p> Distressed Lack of dignity / respect Upset / sad Lack of privacy Lack of peace / calm Agitated / restless Not listened to Frightened / worried Angry / frustrated Other?	<p>Spiritual / religious needs</p> <p>Are the things important to you being considered?</p> Support from faith leader Faith Prayers / rights / rituals Music Things that help you cope Other?

Assessment completed by:

Name (*print*) Designation & NMC:..... Signature.....

Completed and discussed with: (*please circle*) patient / carer / relative: Name

Date completed: Time:

ADVICE from Specialist Palliative Care: JCUH: ext 54787/54718/bleep via switch. MR&C community: 01287 639100.

H&R community and Friarage Hospital: 01609 751313. Out of hours via JCUH switchboard.

For referral forms see Home > Services A-Z > Palliative care.

Patient Name:..... D.O.B.:..... NHS/hospital no:.....

Care Plan Number : 25 Care Plan for the Last Days of Life	
<p>Problem: There is recognition that..... may be nearing the last days of life</p>	<p>Goal(s): For the patient and relative/carer to be informed and involved in decision making</p> <ul style="list-style-type: none"> • The focus of care to be on maintaining comfort and dignity • For patient/relative/carer to be given the opportunity to discuss what is important to them • Mouth is clean and moist; free from discomfort/oral nutrition & hydration ability assessed • Patient is comfortable and in a safe environment • 5 main end of life symptoms are managed: • Pain • Agitation/restlessness • Respiratory tract secretions • Nausea & vomiting • Breathlessness
<p>Consider - does the patient understand and retain the instructions being given. If not, adopt different approaches to meet their individualised needs prior to nursing interventions.</p> <p>Every patient has the right to self-determine what care and/or treatment they receive, as long as they have the capacity to do so. In the absence of capacity for a decision (which needs to be evidenced) care and or treatment needs to be delivered following the best interest principle of the Mental Capacity Act (2005)</p>	
Care Plan	Initial Assessment
<p>25a) The patient is supported to eat and drink for as long as they want and / or are able to. The Registered nurse will assess the patient if he / she is symptomatically dehydrated, and consider artificial hydration (by subcutaneous fluids) if in the patient's best interest.</p>	
<p>25b) Offer regular mouth care to promote patient comfort. Registered nurse to teach, supervise and encourage health & social care assistants / carers / relatives, where appropriate, to offer mouth and lip- care, sips of fluid / ice chips. Consider addition of mouth-care care plan if a particular problem</p>	
<p>25c) Skin care to be provided to ensure patient's skin is clean, dry and comfortable. The patient is moved for comfort only, using pressure relieving aids as appropriate, e.g. a special mattress. Registered nurse to teach, supervise and support health care assistants / carers / relatives to assess, monitor and report to</p>	

Patient Name:..... D.O.B.:..... NHS/hospital no:.....

<p>nursing staff skin condition and integrity. Consider addition of wound care plan</p>	
<p>25d) Personal care to be provided according to individual needs. If they wish, involve relative / carer in care giving. Registered nurse to supervise and support health care assistants / carers / relatives to provide personal hygiene.</p>	
<p>25e) Registered nurse will assess, monitor and, where appropriate, manage the patient's urinary continence needs by use of continence products, urethral catheter, commode, and urinal and / or bed pan. Registered nurse will teach, monitor and supervise health care assistants / carers / relatives where appropriate. Registered nurse will assess, monitor and, where appropriate, manage bowel evacuations to ensure comfort. If appropriate, medication and / or continence products to be provided to maintain dignity.</p>	
<p>25f) All staff to ensure the individual is assisted to communicate their needs <small>via</small> their usual channels of communication with additional support where necessary i.e. the use of pictorial aids and information. If agreed with the patient ensure that their treatment, medication and plan of care (including any changes) is fully communicated to the patient (if possible) their relatives, carers and other relevant persons. Ensure that the verbal discussions are supported by providing a leaflet, 'When Someone is dying'. Remember to consider organ/tissue donation-refer to policy G15</p>	
<p>25g) Registered nurse to liaise with medical practitioner and / or specialist palliative care team if psychological or symptom management support needed. Remember to consider the addition of a spirituality care plan and liaison with Chaplaincy team</p>	
<p>25h) Request that medical practitioner/nurse prescriber prescribes medication for use 'as required' for the five common end of life symptoms defined above. Request that medical practitioner reviews current medication and prescribes by an appropriate route any medication that should continue for symptom management.</p>	

Patient Name:..... D.O.B.:..... NHS/hospital no:.....

<p>25i) Pain</p> <p>The Registered Nurse will undertake an assessment to identify potential physical, psychological and environmental causes of pain.</p> <p>All staff to ensure comfort measures are available, e.g. call bell, pillows, positional change.</p> <p>Administer prescribed medication(s) by the appropriate route and / or non- pharmacological interventions, alongside regular assessment and review.</p> <p>Document the frequency, intensity and type of pain. Use pain assessment tool / diary if appropriate</p> <p>Registered Nurse to liaise with Medical Practitioner and / or Specialist Palliative Care Team, if symptoms remain uncontrolled and / or side effects problematic</p>	
<p>25j) Breathlessness</p> <p>The Registered Nurse will undertake an assessment to identify potential physical, psychological and environmental causes of breathlessness.</p> <p>All staff to ensure comfort measures are available, e.g. fan, open window, positional change.</p> <p>Administer prescribed medication(s) by the appropriate route and / or non- pharmacological interventions, alongside regular assessment and review.</p> <p>Document episodes of distress caused by breathlessness</p>	
<p>25k) Respiratory Tract secretions</p> <p>The Registered Nurse will undertake an assessment to identify potential physical, psychological and environmental causes of respiratory tract secretions.</p> <p>Consider potential concerns of relatives / carers regarding noisy breathing. Explain that although upsetting, it often does not distress the dying person.</p> <p>Administer prescribed medication(s) by the appropriate route and / or non- pharmacological interventions, alongside regular assessment and review.</p> <p>Document the presence of distressing respiratory tract secretions</p>	

Patient Name:..... D.O.B.:..... NHS/hospital no:.....

<p>25l) Nausea & vomiting</p> <p>The Registered Nurse will undertake an assessment to identify potential physical, psychological and environmental causes of nausea and / or vomiting.</p> <p>All staff to ensure comfort measures are available e.g. call bell, bowl, and tissues.</p> <p>Administer prescribed medication(s) by the appropriate route and / or non-pharmacological interventions, alongside regular assessment and review.</p> <p>Document the frequency and volume of vomiting.</p>			
<p>25m) Restlessness/agitation</p> <p>The Registered Nurse will undertake an assessment to identify potential physical, psychological and environmental causes of agitation and / or restlessness</p> <p>All staff to consider comfort measures, e.g. environment, music, familiar voices, spiritual needs</p> <p>Exclude reversible causes, e.g. retention of urine, constipation</p> <p>Administer prescribed medication(s) by the appropriate route and / or non- pharmacological interventions, alongside regular assessment and review.</p> <p>Document episodes of agitation and / or restlessness and evaluate outcome of interventions.</p>			
<p>RESOURCES Medical guidance: Intranet > Services A-Z > Palliative Care > End of Life Care > (various documents) Nursing Care Plans: Intranet > Services A-Z > Nursing & Midwifery > Nursing Care Plans</p>			
<p>Additional interventions required:</p> <ul style="list-style-type: none"> • • 			
Start Date:	Designation & Name	Signature	NMC
Countersignature			

Patient Name:..... D.O.B.:..... NHS/hospital no:.....

Daily Ongoing Assessment
 (Minimum 4 hourly within inpatient areas)

Place of care (home/ward):

	Record your assessment Y (Yes) N (No)									
Date										
Time										
Is the patient free of pain?										
Is the patient free of agitation / distress?										
Is the patient untroubled by respiratory tract secretions?										
Is the patient free of vomiting and / or nausea?										
Is the patient's breathing clear and comfortable?										
Is the patient free of continence problems (bladder / bowels)?										
Is the patient's mouth comfortable, moist and clean?										
Is the patient free of other symptoms? Please specify:										
Is the patient's skin integrity maintained?										
Are the patient's personal hygiene needs met?										
Are the patient's needs for their psychological and spiritual wellbeing met?										
Is the patient receiving care in a physical environment that supports their individual needs?										
Is the wellbeing of the relative / carer 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.

