

Patient Name: DOB:

Hospital No:

NHS No:

**THE PERSONALISED CARE FRAMEWORK FOR THE LAST DAYS OF LIFE**

**NURSING CARE ASSESSMENTS**

**All assessments /care should be documented and initialled by the person carrying out the care.**

**This includes but is not limited to HCSWs, RNs, CNSs and chaplains.**

**All documentation must be countersigned by the registered nurse looking after patient at end of shift**

**NURSING SIGNATORY RECORD**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Print Name*** | ***Band*** | ***Ward*** | ***Signature*** | ***Initials*** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Guidance for Nurses**

**Full copy of the Guidance for Nurses: *Personalised Care Plan for the Last Days of Life:* is available on Microguide under Death and Dying**

* **Diagnosing dying is an MDT decision and must include the patients Consultant or Specialist Registrar**
* **Ensure the Medical Care Plan has been completed in full**
* **Communication with the patient and family is essential and all conversations must be recorded.**
* **Information for relatives and friends of those close to the end of their life leaflet*:* must be offered to relatives and carers**
* **Patients who wish to drink should be offered drinks and assistance at regular intervals**
* **The patient may wish to continue drinking even when unable to swallow or the family may wish to continue offering drinks; sensitive communication is required explaining why it is unsafe to do so, however some patients may still choose to drink despite the risk.**
* **Patients who are able to eat should be offered food and assisted with this at regular intervals. Families who wish to participate should be encouraged to do so**
* **Regular mouth care is essential for the dying patient. Families who wish to participate should be supported to do so**
* **All care offered should be recorded in the daily nursing goals, even care that is declined**
* **It can often be difficult to discern a patient’s spiritual/religious needs. The Chaplaincy Team are available 24/7 to help you. They can support people who are of all faiths or none. If in doubt always call the Chaplain on Ext 4271 or via switchboard.**

**Any problematic symptoms require regular review including:**

* **Pain**
* **Nausea or Vomiting**
* **Agitation or restlessness**
* **Respiratory tract secretions**
* **Breathlessness**

**If symptoms are not resolved with non-pharmacological measures, or anticipatory medications, please request a medical review.**

**Advice and support available from the EoLC Nurses on bleep 1266 or Ext: 5190**

**(Monday-Friday 8am-14.30)**

**For advice on symptom control issues, contact the hospital palliative care team**

**bleep 1293 (Monday-Friday)**

**Out of hours advice on Symptom control contact the Hospice on Ext: 2113**



Patient Name: DOB:

Hospital No:

NHS No:

**THE PERSONALISED CARE FRAMEWORK FOR THE LAST DAYS OF LIFE**

**INITIAL NURSING CARE ASSESSMENT**

|  |  |  |
| --- | --- | --- |
| **Recognition of dying**  *(The PCF medical care plan for the last days of life must be completed prior to starting this assessment)*  **Date PCF commenced:………………….. End of life care Team notified (Ext 5190)**  O **Yes** O **No** | | |
| **Is the patient aware that they are dying**  **Is the patient’s NOK aware that the patient is dying** | O **Yes** O **No If no, why …………………………………….**    O **Yes** O **No If no, why………………………………………** | |
| **Family / Friend / Carer contact details** | | |
| **If the patient’s condition changes, who should be contacted?** | | |
| 1st contact: name: ……………………………………………………………  Relationship to patient: ……………………………………………………  Telephone no: ………………………………………………………………….  Mobile no: ………………………………………………………………………..  At any time: O Not at night time: O  **Would anyone like to be present at the time of death if**  **possible?** | | 2nd contact: name: ……………………………………………………………  Relationship to patient: ……………………………………………………  Telephone no: ………………………………………………………………….  Mobile no: ………………………………………………………………………..  At any time: O Not at night time: O  O **Yes** O **No if yes, who? ………………………………………………………………………….** |
| **Information and explanation of facilities** | | **Who is important to the patient?** |
| Relatives and carers to be given a full explanation of  facilities available to them (should include verbal and  written information)  **Info for relatives and friends of those close to the end**  **of their life leaflet given** O **Yes** O **No**  **Open visiting offered** O **Yes** O **No**  **Ward telephone number given** O **Yes** O **No**  **Nearest toilets / refreshments** O **Yes** O **No**  **Practical info leaflet given** O **Yes** O **No**  **Car parking voucher** O **Yes** O **No**  **Meal voucher** O **Yes** O **No**  **Relative comfort pack**  O **Yes** O **No**  **League of friends bungalows**  O **Yes** O **No**  **Syringe driver info sheet given** O **Yes** O **No**  O **N/A**  Most leaflets / information can be found in the End of life  care purple box or folder | | Document the names and relationships of key people to the patient including who they wish information to be given to. **Please include family members, carers and significant others. Also include significant pets.**  It may be helpful to draw a family tree. |

**DAY ONE: DATE……………………..**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **What is important to the patient?**  Find out what is important to the patient at this time, if the patient is unable to vocalise please ask family members | | | | | | | | |
| **Is the patient able to vocalise?**  □ Yes □ No  **How can communication with the patient be helped?**  hearing aids / glasses / talking to a particular side / other (please circle) ……………………………  **Are necessary aids available and working?**  □ Yes □ No □ N/A  Comments ……………………………………………………. | | **What is important to the patient and their loved ones? E.g. comfort, certain people, pets, place, communication, music etc**  ***Consider using what is important to me resource included in this pack*** | | | | | | |
| **Nursing observations** | | | | | | | | |
| **The following observations and escalation plan have been discussed and agreed with the medical team** (see medical care plan).    **If urgent review needed contact**  **……………………………………………………………………………………….**  **All patients should be reviewed regularly to check they are comfortable and not distressed.** | | |  |  |  | | --- | --- | --- | | **Comfort Observations**  Heart rate  BP  Respiratory rate Temperature  Oxygen saturations  Blood sugar | **O Yes**  **O Yes**  **O Yes**  **O Yes**  **O Yes**  **O Yes**  **O Yes** | **O No**  **O No**  **O No**  **O No**  **O No**  **O No**  **O No** |   **Agreed observations to continue:** | | | | | | |
| **Please use the comfort observation chart included in pack** | | | | | | |
| **Nursing Assessments** | | | | | | | | |
| **Braden:** O At risk O Moderate O High O Very high    **SKIN bundle:** O Yes O No | | **Falls risk** : O Low O High O Extreme  **Is intentional rounding indicated?**  O Yes O No | | | | | | |
| **Symptom Assessment and Management** | | | | | | | | |
| **Always consider whether any symptoms observed are reversible, and can be managed with non-pharmacological interventions**  **PAIN:**  If unable to vocalise look for frowning, facial grimacing, moaning, tense body language, striking out. Is the patient in need of a position change? Is abdominal pain due to constipation or urinary retention? PRN analgesia (PR Paracetamol or S/C opioids) may be indicated  **AGITATION:** could be caused by opioid toxicity, rectal loading, urinary retention, hypoxia and hypercalcaemia; all of which can be managed without requiring sedation  **RESPIRATORY TRACT SECRETIONS:**  Consider change of position. If patient is receiving artificial hydration, request a review of fluid requirements. Medication should be given at early signs of symptoms.  **NAUSEA AND VOMITING**  use antiemetic via s/c route and consider continuous subcutaneous infusion  **BREATHLESSNESS**: Consider change of position and the use of a fan. Low dose opioids can be beneficial  **Seek advice from medical team, or EOLC or palliative care team if needed** | | | | **Have anticipatory medications been prescribed?**  **O Yes O No**  **Comfort observations commenced**  **O Yes O No**  if no why not **…………………………........................**  **Are any of the following symptoms evident?**  O Pain (including location) .....................................  O shortness of breath  O nausea  O vomiting  O restlessness  O confusion  O urinary retention  O respiratory tract secretions  O constipation  O Other ……………………………………………………………….. | | | | |
| **Nutrition and hydration** | | | | | | | | |
| * During someone’s last days of life, the enjoyment of eating and drinking can enhance comfort and a sense of well-being. This can mean that the benefits of eating and drinking for comfort may now outweigh previous risks associated with eating & drinking. Please see “eating and drinking for comfort” guidance under EOLC on Microguide. * Patients unable to take adequate oral fluids/food will have MDT decision regarding artificial hydration and nutrition. Please see the medical plan | | **Hydration**  □ Beaker  □ Straw  □ Spoon  □ Sponges  □ S/C  □ IVI  **Nutrition**  □ Eating  □ NG/PEG  □ TPN  □ Comfort | | **Is the patient able to drink?**  **O Yes**  The benefits of eating and drinking for comfort should have been discussed acknowledging any associated risks. The patient should be supported to eat and drink and regular mouth care should also be provided  **O No**  They are currently unable to drink and eat due to their physical condition and should receive *regular* mouth care.  **Additional information:**  eg likes/dislikes, recommended textures, thickener  ………………………………………………………  ……………………………………………………… | | | |  | |
| **Assessment of patient’s mouth** | | | | | | | | |
| * Regular mouth care is essential for the patient’s comfort, to keep the mouth moist, free of debris and reduce the risk of infection * The patient’s mouth should be assessed every shift and medical team informed if treatment is indicated. * If the patient is unable to drink, aim for hourly mouth care with soft toothbrush/pink sponges * Consider whether oral gel or saliva replacement is indicated   Request Dr review if signs of oral thrush | | **Mouth care**  □ soft toothbrush □ pink sponges □ oral gel  □ prescription  □ medical r/v | | **Initial mouth care assessment score:**    **0**= mouth and lips are clean and moist  **1**= mouth is dry and clean  **2**= some debris/ dried secretions  **3**= persistent dried debris, or signs of oral thrush  **Action Plan:**  Mouth care to be carried out ……. hrly | | | |  | |
| **Personal Hygiene and Elimination** | | | | | | | | |
| * Please promote continence at all times * Offer assistance to pass urine regularly. * Check conveens / catheters for patency and empty * Urine retention should be ruled out in all patients with agitation. Consider bladder scan | | **Aids:**  □ Toilet  □ Bottle  □ Commode  □ Pads  □ Conveen  □ Catheter | | **Is the patient passing urine?**  O Yes O No  **Does the patient have a buzzer within reach?**  O Yes O No O Unconscious  **How often should pt be offered assistance?**  **………………………………………………………** | |  | | |
| * Please promote continence at all times * Offer assistance to open bowels regularly. * Constipation should be considered in all patients with discomfort or agitation. Consider PR. | | **Aids:**  □ Toilet  □ Commode  □ Pads  □ other  ….……………..  **Treatment:**  □ Laxatives  □ Supps  □ Enema  □ Manual | | **When did patient last open their bowels?**  Date: \_\_\_/\_\_\_/\_\_\_  Type: ………………… Quantity………………………….    **Stool chart should be maintained**  Record action taken if no bowel movement for 3 days. | | |  | |
| * Relatives / carers should be involved as appropriate. * Please brush teeth / clean mouth at beginning of wash | | **Today**  □ Bed bath  □ Bath  □ Shower  □ Declined | | **How are the patient’s personal hygiene needs to be met?**  **Any specific needs / requests …………………………………** | | | |  | |
| * Please use appropriate Manual handling aids | | □ Skin bundle  □ Air mattress  □ Pressure  Sore  □ Tissue viability referral | | **How is the patient’s skin integrity being maintained?**  Frequency of repositioning : …………hrly  If pressure sore: Location: ……………… Grade: ………  Photographed: □ yes □ no  Reported: □ yes □ no  Datix number: …………………. | | | |  | |
| **Cultural, spiritual, psychological, emotional, religious needs** | | | | | | | | |
| * Please ensure that the chaplaincy team have been notified of this patient whether or not involvement required (ext 4271) | | Religion of pt:  ……………………… | | **What cultural spiritual, emotional, religious needs have been identified?**  …………………………………………………………………………………………….  **Is faith important to**  **the patient:** O Yes O No  **their loved ones:** O Yes O No | | | |  | |
| **Communication & support of loved ones** | | | | | | | | |
| **Has the patient had any visitors today?**  O Yes O No  **If yes, who? ………………………………………………………….**  Support: □ Refreshments offered □ Supported by Chaplaincy □ Communication with medical team □ Other  **Please document any communication with / concerns raised by relatives / carers**  ……………………………………………………………………………………………………………………………………………………………………………………………………………  …………………………………………………………………………………………………………………………………………………………………………………………………………… | | | | | | | |  | |
| **Summary of shift: (DAY) (to be completed by RN responsible for patient)** | | | | | | | |
| **This assessment has been completed by RN** Sign, Print, Band……………………………………………………………………………………………….. | | | | | | | |
| **Summary of shift: (NIGHT) (to be completed by RN responsible for patient)** | | | | | | | |
| **This assessment has been completed by RN** Sign, Print, Band……………………………………………………………………………………………….. | | | | | | | |

**All assessments /care should be documented and initialled by the person carrying out the care. This includes**

**but is not limited to HCSWs, RNs, CNSs and chaplains. All documentation should be countersigned by registered nurse looking after patient at end of shift**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Comfort Observation Chart** | | | | | \\Sdh-public\public\Medicine-Directorate\EOLC\EOLC provision\EOLC photos\EOLC butterfly.jpg | | | | | Name    Hospital No  Date of Birth  (or affix patient label) | | | | | | | | | | |
| **SCORING** | **0= Symptom absent** | **1= MILD**  **-Symptom is mild.**  **-No obvious distress noted.**  **-Resolves spontaneously or with minimal intervention.** | | | **2= MODERATE**  **- Patient distressed by symptom.**  **-Symptom persists after non-pharmacological measures.** | | | | | | | | | **3= SEVERE**  **-Symptom causing significant distress to patient and/or**  **-Symptom persists despite previous interventions** | | | | | | |
| **ACTION** | **-No intervention required**  **-Continue 4 hourly assessments** | **-Look for reversible causes (use non-pharmacological measures) e.g. repositioning, check catheter.**  **- Reassess after 1 hour if action taken otherwise continue 4 hourly assessments**  **- Escalate if mild symptoms persist** | | | **- Consider reversible causes and consider non-pharmacological actions.**  **- Give medication if indicated.**  **-Review hourly until symptom resolved.**  **- Escalate if symptoms persist.**  **-Document actions.** | | | | | | | | | **- Consider reversible causes and non-pharmacological actions**  **- Give medication for symptom**  **- Review hourly until symptom resolved**  **-Persistent symptoms require escalation to medical team or CNS**  **-Document actions** | | | | | | |
| **All actions should be documented on the reverse of this sheet** | | | | | | | | | | | | | | | | | | | | |
| **Date** | | | |  | |  |  |  |  | |  |  |  | |  |  |  |  |  |  |
| **Time** | | | |  | |  |  |  |  | |  |  |  | |  |  |  |  |  |  |
| **PAIN** | | | Score |  | |  |  |  |  | |  |  |  | |  |  |  |  |  |  |
| Action Y/N |  | |  |  |  |  | |  |  |  | |  |  |  |  |  |  |
| **AGITATION/ RESTLESSNESS** | | | Score |  | |  |  |  |  | |  |  |  | |  |  |  |  |  |  |
| Action Y/N |  | |  |  |  |  | |  |  |  | |  |  |  |  |  |  |
| **RESPIRATORY TRACT SECRETIONS** | | | Score |  | |  |  |  |  | |  |  |  | |  |  |  |  |  |  |
| Action Y/N |  | |  |  |  |  | |  |  |  | |  |  |  |  |  |  |
| **NAUSEA and/or VOMITING** | | | Score |  | |  |  |  |  | |  |  |  | |  |  |  |  |  |  |
| Action Y/N |  | |  |  |  |  | |  |  |  | |  |  |  |  |  |  |
| **SHORTNESS OF BREATH** | | | Score |  | |  |  |  |  | |  |  |  | |  |  |  |  |  |  |
| Action Y/N |  | |  |  |  |  | |  |  |  | |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **MOUTH CARE** | | **0**= mouth and lips are clean and moist  **1**= mouth is dry and clean  **2**= some debris/ dried secretions  **3**= persistent dried debris, or signs of oral thrush | Score |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Aim for hourly mouth care with soft toothbrush/ pink sponges  Consider whether oral gel or saliva replacement indicated  Dr review for oral thrush treatment | Mouth care given  Y/N |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Action Y/N |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **BOWEL CARE** | | **0**= bowels opened within last 48hours  **1**=BNO< 3 days  **2**=BNO > 3 days no symptoms  **3**= BNO > 3days symptomatic  (restless / abdominal pain) | Score |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Consider oral magnesium Hydroxide  If BNO > 3days PR +/- suppositories  If continued BNO consider enema cycle- escalate to medical team | Action  Y/N |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **URINARY CARE** | | **0**= passing urine without difficulty  **1**= catheter in situ and draining  **2**= catheter bypassing  **3**= urinary retention | Score |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Bladder Scan.  Consider alternatives- urinary catheter/convene drainage  Check catheter patency | Action  Y/N |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **INITIALS** | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **BAND** | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Please use this comfort observation chart to regularly assess for symptoms (min 4 hrly)**  **Document your assessment and any actions below.**  **Remember to reassess after one hour (min) following an intervention for effectiveness** | | | | | |
| **Always consider whether any symptoms observed are reversible, and can be managed with non-pharmacological interventions**  **Seek advice from medical team, or End of life Care CNS team (blp1266) or specialist palliative care team (blp 1293) if needed.** | | | | | |
| **Time and Date** | **Symptom** | **Intervention** (incl. PRNs given) | **Effectiveness** | **Initial** |
|  |  |  |  |  |

