Bradford District NHS Care Trust

Patients Name: .....NHS no. .....Date: .....

Last Days of Life Care - Assessment of Need

	Time	Time	Time	Time	Time	Time
Record a Yes or No next to goal						
Goal A: Does the patient have pain						
Verbalised by patient if conscious, pain free on movement. Observe for non-verbal cues. Consider need for positional change. Use a pain assessment tool if appropriate. Consider prn analgesia for incident pain.						
Goal B: Is the patient agitated						
Patient does not display signs of restlessness or distress, exclude reversible causes e.g. Retention of urine, opioid toxicity.						
Goal C: Does the patient have respiratory tract secretions						
Consider positional change. Discuss symptoms and plan of care with patient and carer. Medication to be given if symptoms present						
Goal D: Does the patient have nausea						
Verbalised by the patient if conscious						
Goal E: Is the patient vomiting						
Consult GP or Palliative Care Nurse Specialist						
Goal F: Is the patient breathless						
Verbalised by patient if conscious, consider positional change. Use of a fan may be helpful						
Goal G: Does the patient have any urinary problems.						
Use of pads or urinary catheter if necessary.						
Goal H: Does the patient have bowel problems.						
Constipation / Diarrhoea, monitor skin integrity.						
Goal I: Does the patient have any other symptoms			**q**			
Record symptoms in d/n record.						
Goal J: Have you identified any issues with skin integrity						
Assess / cleansing / positioning and frequency / use of equipment i.e. Bed / mattress / record Maelor						
Goal K: Is the patient able to take fluids						
Support fluid intake as tolerated. Monitor for aspiration / distress. Discuss related symptoms with patient / carer.						

Goal L: Does the patient have any mouth care needs						
See mouth care policy - involve carer in giving appropriate mouth care. Use baby toothbrush.						
	Time	**Time**	**Time**	**Time**	**Time**	**Time**
Goal M: Are the patients personal hygiene needs being met						
Skin care / washing / eye care / change of clothing according to individual needs. Carer involved in care giving as appropriate.						
Goal N: Appropriate medication available for symptom management						
Anticipatory / Syringe Driver / Gold Box in place.						
Goal O: The patient's psychological well-being is maintained						
Verbal and non-verbal comunication is maintained. Involve the carer in supporting the patient, this can be through touch / verbal communication.						
Goal P: Is the well being of the carer maintained						
Consider Spiritual / Religious / Cultural needs. Offer age appropriate advice / support. Listen and respond to worries or concerns. Involve gp / Special Nurse as appropriate with consent.						
Signature of person making the assessment:						