Nursing Daily Evaluation
Last Hours & Days of Life

St George's University Hospitals NHS
NHS Foundation Trust

IMPORTANT INFORMATION

This care plan should only be used when:

1. There is a clearly recorded decision documented in the patient's medical notes, by the senior clinician in charge of their care, that the patient is felt to be in the last hours or days of life.
2. There is an individualised end of life care plan recorded in the patient's medical notes.
3. Family or carers are in agreement with the above decisions
4. Only to be used for adult patients.

Patient's Name:

Hospital Number:

Patients D.O.B:

Date commenced care plan:

Communicate / Document / Rationalise / Care / Symptoms / Family / Spirituality / After Care

COMMUNICATE

with patient / family to clarify aims of care; update family on a regular basis and following any change in management. In particular, consider and explain resuscitation, hydration, sedation and use of medications.

DOCUMENT

significant conversations and daily evaluation in the notes

REVIEW INTERVENTIONS AND MEDICATIONS

focus on comfort and dignity

- Consider and explain interventions based on a balance of benefits and burdens
- Communicate decisions with patient (where possible) and family

MAINTAIN EXCELLENT BASIC CARE

frequent assessment (at least 4 hourly), action and review

- Regular mouth care
- Turning for comfort as appropriate
- Encourage & support oral food / hydration as patient able
- Check bladder and bowel function
- Ensure dignity and compassion in all care

ASSESS SYMPTOMS REGULARLY

frequent assessment (at least 4 hourly), action and review

- For example pain, nausea, agitation, respiratory secretions or breathlessness
- Assess and record any medications given
- Medications may be required via subcutaneous syringe pump if symptomatic/no longer tolerating oral medications
- Advice available from the Palliative Care Team, 9-5 Mon –Sun via bleep 6508. Outside these hours contact on call SpR at Trinity Hospice on 0207 787 1000

IDENTIFY SUPPORT NEEDS OF FAMILY

consider need for IMCA/interpreter

- Ensure contact numbers and contact preferences updated for key family members
- Explain facilities available e.g. accommodation, parking permits, folding beds if available
- Consider single room for patient if available

IDENTIFY SPIRITUAL NEEDS

for both patient and family

- Document specific actions required
- Refer to chaplaincy as appropriate

CARE AFTER DEATH

- Timely verification of death and informing of family
- Provide family with bereavement services information
- Inform GP and other involved clinicians

Nurse commencing care plan:

Nurse's Signature