									Name:							D.O.B. DD / MM / YYYY					
Ongoing a	asse	ssn	nent	and	d red	cord	of o	care	nee	eds											
For adults, this											vatio	on char	·†								
							•	_													
To be complete review hourly. E																			ssess	and	
Date Todary.	113010	(1113	ушрс		030176			3 useu	III CC			VVICII CI		liti dis	Cipiiii	ury ca	10100	l l			
Time																					
Initials																					
1. PAIN																					
Severe																					
Moderate																					
Mild/None																					
2. NAUSEA and/or	· VOMI	TING		-																	
Severe																					
Moderate																					
Mild/None																					
3. AGITATION																			,		
Severe																					
Moderate																					
Mild/None			_																		
4. RESPIRATORY S	ECRETI	ONS (	conside	er post	ural ch	nange)															
Distressing																					
Not Distressing	DDEAT	-11/			**1			20		.1		. \									
5. SHORTNESS OF Distressing	BKEAI	н (e.g	. in pat	ients v	vith res	spirato	ry rate	over 20	brea	itns per	minu	ite)									
Not Distressing																					
6. THIRST AND HU	INGER																				
Distressing	NOLI																				
Not Distressing																					
7. DRY MOUTH – I	f Yes, C	onside	er offei	rina sir	os, drin	ıks, mo	uth ca	re if apr	oropri	iate											
Yes	,			<u> </u>		•			<u> </u>												
No																					
8. MICTURITION /	URINE	OUTP	UT / RE	TENTI	ON																
Distressing																					
Not Distressing																					
9. BOWEL MOVEN	IENT C	ONCER	RNS (re	port co	onstipa	ation o	r diarrh	oea an	d care	e given	)		,								
Yes																					
No																					
10. SKIN AND PRE	SSURE	AREAS	SINCLU	JDING	WOUN	IDS (co	nsider	eguipn	nent,	regular	posit	ioning	and su	ıpplem	entary	care p	lans if	neede	d)		
Not Satisfactory									<u> </u>												
Satisfactory																					
11. OTHER (e.g. hi	ccups,	itch, n	ose ble	ed) de	scribe:																
Yes																					
No																					
					,				Ple	ease re	port	on the	Care	Recor	d (fro	m pag	je 14)				
12. MEDICATION:		Please report on the Care Record (from page 14)  Check its effectiveness, involve the patient and those important to them.																			
										eport at											
13. PSYCHOLOGICAL STATE:									Wh	What can be observed? Does the patient appear calm, anxious, distressed?											
									-Re	eport at	least	daily.									
14. SPIRITUAL AND CULTURAL NEEDS ASSESSED AND MET?												lp addre						or care	before	and	
15. COMMUNICATION WITH THE FAMILY AND THOSE IMPORTANT TO												hat's im	portai	nt to th	em rig	ht now	?"				
15. COMMUNICA THE PATIENT:	TION V	viiHT	HE FAN	/IILY Aİ	אט וּHי	USE IM	IPORTA	ANT FO	-Re	-Report at least daily.											
16. OVERALL CO	ידוחאנ	ON							lc t	Is this care plan still appropriate? Is the patient still thought to be d								he dvi	ing?		
. J. J F LIMEL CC		-11							1 13 (	s cal	- Pial	. Juli ap	hiohii	atc: 13	are par			911110	ac uyi	y.	
Look for reversible causes.																					
Severe		Consi	der no	n-phar	macol	ogical <sup>.</sup>		ent e.g.													
	1				r symp	otom a	nd revi	ew unt	il Milc	d/None		Mild/N	one		No	interve	ention	requir	ed.		
Moderate	١.		s achie ment A		الحو دىن	pplem	entarv	care pl	ans if	require	' <sup>q</sup>										
	<u> </u>	20cui	ment P		JJC 3U	Phicili	circui y	curc pr	a113 11	require	. ч										

## Ongoing assessment and record of care needs For adults, this chart supercedes the standard Early Warning Score observation chart. To be completed every 4 hours or at each visit in line with local policy or if symptoms are moderate or severe please assess and review hourly. Ensure this symptom observation chart is used in conjunction with the multi-disciplinary care record. Date Time Initials 1. PAIN Severe Moderate Mild/None 2. NAUSEA and/or VOMITING Moderate Mild/None 3. AGITATION Severe Moderate Mild/None 4. RESPIRATORY SECRETIONS (consider postural change) Distressing Not Distressing 5. SHORTNESS OF BREATH (e.g. in patients with respiratory rate over 20 breaths per minute) **Not Distressing** 6. THIRST AND HUNGER Distressing **Not Distressing** 7. DRY MOUTH – If Yes, Consider offering sips, drinks, mouth care if appropriate No 8. MICTURITION / URINE OUTPUT / RETENTION Distressing Not Distressing 9. BOWEL MOVEMENT CONCERNS (report constipation or diarrhoea and care given) Yes 10. SKIN AND PRESSURE AREAS INCLUDING WOUNDS (consider equipment, regular positioning and supplementary care plans if needed) **Not Satisfactory** Satisfactory 11. OTHER (e.g. hiccups, itch, nose bleed) describe: Yes No Please report on the Care Record (from page 14) 12. MEDICATION: Check its effectiveness, involve the patient and those important to them. -Report at least daily. 13. PSYCHOLOGICAL STATE: What can be observed? Does the patient appear calm, anxious, distressed? -Report at least daily. 14. SPIRITUAL AND CULTURAL NEEDS ASSESSED AND MET? How we can help address personal beliefs and wishes for care before and after death. "What's important to them right now?" 15. COMMUNICATION WITH THE FAMILY AND THOSE IMPORTANT TO -Report at least daily.

Severe

 Look for reversible causes.
 Consider non-pharmacological treatment e.g. positioning
 Give medication for symptom and review until Mild/None level is achieved.
 Document Action/Use supplementary care plans if required

Mild/None No intervention required.

Is this care plan still appropriate? Is the patient still thought to be dying?

Adapted from original document © Department of Palliative Medicine, University Hospitals Bristol NHS Foundation Trust. Author(s) R McCoubrie, C Reid, J Gibbins & K Forbes. Shared Care Plan for the expected last days of life.

THE PATIENT:

**16. OVERALL CONDITION**