Name:	D.O.B. DD / MM / YYYY

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

Severe																				
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)

Distressing																				
Not Distressing																				

6. THIRST AND HUNGER

Distressing																				
Not Distressing																				

7. DRY MOUTH – If Yes, Consider offering sips, drinks, mouth care if appropriate

Yes																				
No																				

8. MICTURITION / URINE OUTPUT / RETENTION

Distressing																				
Not Distressing																				

9. BOWEL MOVEMENT CONCERNS (report constipation or diarrhoea and care given)

Yes																				
No																				

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 THE PATIENT:	-Report at least daily.
16. OVERALL CONDITION	Is this care plan still appropriate? Is the patient still thought to be dying?

Severe Moderate	• 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.

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