Patient's Name:…………………..……… D.O.B.:…………… NHS/hospital no.:………..………

Initial Holistic Nursing Assessment

Please complete with the patient and relative / carer if appropriate. If the patient is unable to contribute to their care assessment, complete on their behalf. Circle any identified problems and cross out those not present.

Physical Problems	**Social / environmental concerns**
Do you have any problems with your comfort? Pain / discomfort Breathlessness Mouth – sore / dry / painful Chest secretions Sputum Cough Swallowing difficulties Feeling sick / being sick Constipation / diarrhoea Urinary problems Catheter care Sweats / hot / cold Skin – sores / wound / dry / itch / weeping Oedema (Swelling) Personal care – washing / hair care Sleep Mobility Other? ………………………………….	**Do you feel the needs of yourself and your family / carers are being met?** Eating / drinking facilities Quiet environment Comfortable surroundings Worries / fears Written information Update on plan of care Support for relative / carer / friend Support for children Financial concerns Parking facilities Other? ………………………………….
Emotional wellbeing	**Spiritual / religious needs**
Do any of these words describe how you feel? Distressed Lack of dignity / respect Upset / sad Lack of privacy Lack of peace / calm Agitated / restless Not listened to Frightened / worried Angry / frustrated Other? ………………………………….	**Are the things important to you being considered?** Faith Support from faith leader Prayers / rights / rituals Culture Music Values Things that help you cope Other? ………………………………….

Assessment completed by:
Name *(print)* ………………………. Designation ………………... Signature ..…………………
Completed and discussed with: *(please circle)* patient / relative / carer: Name ………………….

Date completed: …………………………………..…. Time: ……………………………….

Patient's Name:……………………..……… D.O.B.:…………… NHS/hospital no.:………..………

Initial Nursing Assessment Summary

Please record your assessment of the patient's identified problems below. Ensure that there is a care plan for each identified problem, including review date and time.

Date & Time	Problem Identified / Care plan	Summary of Assessment	Signature & Designation

Patient's Name:……………………..……… D.O.B.:…………… NHS/hospital no.:………..………

End of Life Core Nursing Care Plan

Goals:

The goals for ……………….'s care are:

- to receive a holistic assessment of their needs at the end of life
- for the patient and or relative / carer to be involved with decision making
- for care to be delivered with compassion
- that the focus of care is to maintain comfort and dignity
- ………………………………………………………………………………………………..
- ………………………………………………………………………………………………..

Interventions:

1. The patient is supported to **eat and drink** for as long as they want and / or are able to. The registered nurse will assess the patient if he / she is symptomatically dehydrated, and consider artificial hydration if it is in the patient's best interest.
2. Regular **mouth care** is offered to promote the patient's comfort. The registered nurse should teach, supervise and encourage health and social care assistants / carers / relatives, where appropriate, to offer mouth and lip care, sips of fluid / ice.
3. **Skin care** to be provided to ensure the patient's skin is clean, dry and comfortable. The patient is moved for comfort only, using pressure relieving aids as appropriate, e.g. a special mattress. The registered nurse should teach, supervise and support health and social care assistants / carers / relatives to assess, monitor and report to nursing staff regarding skin condition and integrity.
4. **Personal care** to be provided according to individual needs. Involve relative / carer in care giving, if they wish. The registered nurse to supervise and support health and social care assistants / carers / relatives to provide personal hygiene.
5. The registered nurse will assess, monitor and, where appropriate, manage **bowel evacuations** to ensure comfort. If appropriate, medication and / or continence products to be provided to maintain dignity.
6. The registered nurse will assess, monitor and, where appropriate, manage the patient's **urinary continence needs** by use of continence products, urethral catheter, commode, urinal and / or bed pan. The registered nurse will teach, monitor and supervise health and social care assistants / carers / relatives where appropriate.
7. The registered nurse to **liaise with medical practitioner and / or specialist palliative care team** if psychological or symptom management support needed.
8. …………………………………………………………………………………………………
   …………………………………………………………………………………………………
9. …………………………………………………………………………………………………
   …………………………………………………………………………………………………

Care plan completed by:

Name *(print)* ………….…………..…. Designation ………….…...…. Signature ……………..

Care plan agreed and discussed with: *(circle)* patient / relative / carer Name ……………….…..….

Date care plan commenced: …………….……………..…. Time commenced: ………………..….

Patient's Name:……………………..……… D.O.B.:…………… NHS/hospital no.:………..………

Nursing Communication with Patient and / or Relative / Carer

Please document discussions with the patient and / or relative / carer regarding:

- Patient / relative / carer understanding of the current situation
- The plan of care
- Any questions or concerns which have been raised
- Who to speak to or contact if worried or concerned

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Written information

What written information / leaflets have been given to the patient and / or relative / carer?

………
………

Completed by:

Name *(print)* …………….……….…. Designation …………………...…. Signature ……………….............

Discussed with: *(circle)* patient / relative / carer Name ………………….…...… Date: ……….... Time: ……...