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| --- | --- | --- | --- | --- |
|  | Local logo |  | Patient name: |  |
| NHI: |  |
| DoB: |  |

# Care in the last days of life

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| **Baseline assessment** |
| **Recognition that the person is dying or is approaching the last days of life** |
| Is the *Recognising the Dying Person* *Flow Chart* available to support decision‑making? | Yes ⬜ |
| Diagnosis: |  | Ethnicity: |  |  |
| Lead practitioner name: |  | Designation: |  |  |
| Lead practitioner’s contact no: |  | After-hours contact no: |  |  |
| *Note: The lead practitioner is the person’s GP, hospital specialist or nurse practitioner.* |
| **The person’s awareness of their changing condition** |
| Is the person aware they may be entering the last few days of life? | Yes ⬜ | No ⬜ |
| **The family/whānau’s awareness of the person’s changing condition** |
| Is the family/whānau aware that the person may be entering the last few days of life? | Yes ⬜ | No ⬜ |
| **Family/whānau contact** |
| If the person’s condition changes, who should be contacted first? | Name: |  |  |
| Relationship to person: |  | Phone (H): |  | (Mob): |  |  |
| When to contact: | At any time ⬜ | Not at night-time ⬜ | Staying overnight ⬜ |
| Is an enduring power of attorney in place? | Yes ⬜ | No ⬜ |  |
| Has it been activated? | Yes ⬜ | No ⬜ | N/A ⬜ |
| **Advice to relevant agencies of the person’s deterioration** |
| Has the GP practice been contacted if they are unaware the person is dying?(If out of hours, contact next working day.) | Yes ⬜ | No ⬜ | N/A ⬜ |
| *Note: Consider notifying the person’s specialist teams, district nursing services, residential care and other agencies involved in their care.* |
| Has this assessment been discussed with the person and family/whānau and priorities of care been identified? | Yes ⬜ | No ⬜ |  |
| If not, discuss reasons: |  |  |
|  |
| **Taha tinana – *Physical health*** |
| **Assessment of physical needs** |
| Is the person: | Conscious ⬜ | Semi-conscious ⬜ | Unconscious ⬜ |
| In pain | Yes ⬜ | No ⬜ | Able to swallow | Yes ⬜ | No ⬜ | Confused | Yes ⬜ | No ⬜ |
| Agitated | Yes ⬜ | No ⬜ | Continent (bladder) | Yes ⬜ | No ⬜ | Experiencing respiratory tract secretions | Yes ⬜ | No ⬜ |
| Nauseated | Yes ⬜ | No ⬜ | Catheterised | Yes ⬜ | No ⬜ |
| Vomiting | Yes ⬜ | No ⬜ | Continent (bowels) | Yes ⬜ | No ⬜ | Skin integrity at risk | Yes ⬜ | No ⬜ |
| Dyspnoeic | Yes ⬜ | No ⬜ | Constipated | Yes ⬜ | No ⬜ | At risk of falling | Yes ⬜ | No ⬜ |
| Is the person experiencing other symptoms (eg, oedema, myoclonic jerks, itching)? | Yes ⬜ | No ⬜ |
| Describe: |  |  |
|  |

|  |  |  |  | Patient name: |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  | DoB: |  |
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| **Availability of equipment** |
| Is the necessary equipment available to support the person’s care needs(eg, air mattress, hospital bed, syringe driver, pressure-relieving equipment)? | Yes ⬜ | No ⬜ |
| **Provision of food and fluids** |
| Is clinically assisted (artificial) nutrition in place? | Yes ⬜ | No ⬜ |
|  | If yes, record route: | NG ⬜ | PEG/PEJ ⬜ | NJ ⬜ | TPN ⬜ |
| Ongoing clinically assisted (artificial) nutrition is: |
|  | Not required ⬜ | Discontinued ⬜ | Continued ⬜ | Commenced ⬜ |
| Is clinically assisted (artificial) hydration in place? | Yes ⬜ | No ⬜ |
|  | If yes, record route: | IV ⬜ | Subcut ⬜ | PEG/PEJ ⬜ | NG ⬜ |
| Ongoing clinically assisted (artificial) hydration is: |
|  | Not required ⬜ | Discontinued ⬜ | Continued ⬜ | Commenced ⬜ |
| **Doctor or nurse practitioner to complete** |
| **Review of current management and prescribing of anticipatory medication** |
| Has current medication been assessed and non-essentials discontinued? | Yes ⬜ |  |
| Has the person’s need for current interventions been reviewed? | Yes ⬜ |  |
| **Anticipatory prescribing of medication completed (refer to relevant symptom management flow charts (links):** |
| Pain | Yes ⬜ | Nausea/vomiting | Yes ⬜ |
| Agitation | Yes ⬜ | Dyspnoea/breathlessness | Yes ⬜ |
| Respiratory tract secretions | Yes ⬜ |  |  |
| Have additional treatment and/or care-related issues been discussed with the family/whānau if needed (eg, food, fluids, place of care, ceiling of care, cardiopulmonary resuscitation)? | Yes ⬜ |  |
| **Consideration of cardiac devices:** If a person has a cardiac device (eg, cardioverter defibrillator (ICD) or ventricular assist device), a conversation should take place with the person and/or the family/ whānau to discuss what can occur in the last days of life, whether the cardiac device should be deactivated and, if so, how and when this would take place. |
| Has the cardiac device been deactivated? | Yes ⬜ | No ⬜ | No ICD in place ⬜ |
| **Full documentation in the clinical record is required for any issues identified.** |
| Doctor’s / nurse practitioner’s name (print): |  |  |
| Signature: |  | Date: |  | Time: |  |  |
|  |
| **Taha hinengaro – *Psychological and mental health*** |
| **Assessment of the person’s preferences and wishes for care** |
| Does the person have an advance care plan (ACP) / or other directive? | Yes ⬜ | No ⬜ |
| Has the person expressed the wish for organ/tissue donation? | Yes ⬜ | No ⬜ |
| Has the person expressed a preferred place of care? |
|  | No preference ⬜ | Home ⬜ | ARC ⬜ | Hospital ⬜ | Hospice ⬜ |
| Does the person have a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order in place? | Yes ⬜ |  |
| Does the person have any cultural preferences? | Yes ⬜ | No ⬜ |
| If yes, describe: |  |  |
| Does the person have any emotional or psychological symptoms or concerns? | Yes ⬜ | No ⬜ |
| If yes, describe: |  |  |
|  |
| **Te wairua – *Spiritual health*** |
| **Provision of opportunity for the person and their family/whānau to identify what is important to them** |
| If able, has the person been given the opportunity to express what is important to them at this time (eg, wishes, feelings, spiritual beliefs, religious traditions, values)? *(Refer to the person’s ACP for personal wishes if completed)* | Yes ⬜ | Not able ⬜ |
| Specify if applicable: |  |  |
| Has the family/whānau been given the opportunity to express what is important to them at this time? | Yes ⬜ |  |
| Specify if applicable: |  |  |
| Has the person’s own spiritual advisor/minister/priest been contacted? | Yes ⬜ | N/A ⬜ |
| Name: |  | Contact no: |  | Date/time: |  |  |
| Are there other needs to address(such as access to outdoors, pets, touch therapy, music, prayer, literature, etc)? | Yes ⬜ | No ⬜ |
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| **Te whānau – *Extended family health*** |
| **Identification of communication barriers and discussion of needs** |
| Is the person able to take a full and active part in communication? | Yes ⬜ | No ⬜ |
| Have the cultural needs of the family/whānau been identified and documented? | Yes ⬜ |  |
| Has the person and/or the family/whānau expressed concern about previous experiences of death and dying? | Yes ⬜ | No ⬜ |
| **Provision of information to the family/whānau about support and facilities** |
| Has the family/whānau received information about support and facilities available to them? | Yes ⬜ |  |
| Has the *When Death Approaches* information sheet been offered to the family/whānau? | Yes ⬜ |  |
| If the person is being cared for at home, has the family/whānau received information about who to contact after hours or if the person’s condition changes? | Yes ⬜ |  |
| Has the *Dying at Home* information sheet been offered to the family/whānau? | Yes ⬜ |  |
| Has advice been given to the family/whānau on what to do in an emergency? | Yes ⬜ |  |
| **Full documentation in the clinical record is required for any issues identified in this assessment.** |
| Nurse’s name (print): |  | Date: |  |  |
| Signature and designation: |  | Time: |  |  |
|  |
| **Care after death** |
| It may be appropriate to complete some of this section before the person’s death. |
| **Taha tinana – *Physical health*** |
| **Verification of death** |
| Time of death: |  | Date of death: |  |  |
| Is the person to be buried or cremated? | Burial ⬜ | or | Cremation ⬜ |
| Name of doctor informed of person’s death: |  |  |
| Name of funeral director: |  | Tel no: |  |  |
| Date and time death verified: |  | Who verified the death? |  |  |
|  |  |  |
| **Taha tinana – *Physical health*** (continued) |
| Is the coroner likely to be involved? | Yes ⬜ | No ⬜ |
| Has a medical certificate been completed? | Yes ⬜ | Doctor’s name: |  |  |
| *Note: Relevant members of the multidisciplinary team (MDT) should be advised of the person’s death in a timely fashion (eg, district nurses, hospice, GP/specialist).* |
| **The person/tūpāpaku is treated with dignity and respect.** |
| **Ensure the wishes and cultural requirements of the deceased person and their family/whānau are met in terms of after-death care.** |
| Are valuables to be left on the person/tūpāpaku? | Yes ⬜ | No ⬜ |
|  |  |  |
| *Note: Support the family/whānau to participate in after-death care if they wish to be involved, undertake after-death care according to local policies and procedures and return personal belonging to the family/whānau in a respectful way.* |
| **Te whānau – *Extended family health*** |
| Has the family/whānau been given the opportunity to express spiritual,religious and cultural needs? | Yes ⬜ |  |
| *Note: Provide an opportunity to talk with the family/whānau about their spiritual, religious or cultural needs.* |
| Has a private space been made available for the family/whānau? | Yes ⬜ |  |
| *Note: Respect the family/whānau need for privacy, ensure a private space is available for prayer, karakia or other cultural or spiritual needs and arrange for blessing of the room/bedspace as appropriate.* |
| **The family/whānau is provided with information about what to do next.** |
| Has a conversation been held with the family/whānau to ensure they have adequate information about what to do next? | Yes ⬜ |  |
| Has written material been offered (this may include information regarding local funeral directors, funeral planning, etc)? | Yes ⬜ |  |
| *Note: Additional support should be offered at the time of death if needed. This may include a social worker, cultural support and/or chaplain support.* |
| **Taha hinengaro – *Mental health*** |
| **The family/whānau is able to access information about bereavement support and counselling if needed.** |
| Was the family/whānau present at the time of death? | Yes ⬜ | No ⬜ |
| If not, has the family/whānau been notified? | Yes ⬜ | No ⬜ |
| Name ofperson notified: |  | Relationship to the deceased person: |  |  |
| If no one was notified, explain why not. |  |
|  |  |  |
| Did the family/whānau appear to be significantly distressed by the death? | Yes ⬜ | No ⬜ |
| Was there evidence of conflict that remained unresolved within the family/whānau? | Yes ⬜ | No ⬜ |
| *Note: Written bereavement information should be offered as available.* |
| ***If Yes was ticked to either of the last two questions AND/OR the family/whānau expressed distress at being unable to say goodbye, complete the Te Ara Whakapiri Bereavement Risk Assessment Tool.*** |
| Nurse’s name (print): |  | Date: |  |  |
| Signature and designation: |  | Time: |  |  |
|  |