Name: …….. NHS No: …….. D.O.B: ……..

AGITATION & RESTLESSNESS CORE CARE PLAN

Problem / Need:	**Goal:**
…….. is experiencing agitation and / or restlessness. The probable cause of this is …….. ……..	……. is calm and settled.

Interventions:

1. The Registered Nurse will undertake an assessment to identify physical, psychological and environmental causes of agitation and / or restlessness.
2. All staff to consider comfort measures, e.g. environment, music, familiar voices, spiritual needs.
3. Consider reversible causes, e.g. retention of urine, constipation, noisy environment.
4. Administer prescribed medication consider non-pharmacological interventions, alongside regular assessment and review.
5. Document episodes of agitation and / or restlessness and evaluate outcome of interventions.
6. The Registered Nurse will supervise and support health and social care assistants / carers / relatives to assess, monitor and report to nursing staff if any problems with agitation and / or restlessness.
7. Registered Nurse to liaise with Medical Practitioner and / or Specialist Palliative Care Team, if symptoms remain uncontrolled and side effects are problematic.
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: ……..…

Name: …….. NHS No: …….. D.O.B: ……..

Date & Time	Assessment / Plan / Evaluation	Signature & Designation