Patient 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.

Where there are choices please circle the relevant one.

1. Are you suffering from any of the following?	**Y/N**	**2. Do you/your family have enough support with?**	**Y/N**
Pain/discomfort		Eating and drinking	
Breathlessness		Finding a quiet place	
Cough		Things you are worried/frightened about	
Chest secretions/phlegm		Getting information from us in a way that meets your needs	
Sore/dry/painful mouth		Updates on how you are doing	
Feeling thirsty		Emotional support for you	
Feeling hungry		Emotional support for family/children	
Feeling/being sick		Financial worries	
Constipation/diarrhoea		Parking/transport	
Problem passing urine/incontinence/catheter		Communication and how we understand each other	
Hot/cold sweats		Other…… ……	
Skin Condition – pressure care/ sores/wound/dry/itchy			
Fluid collection (oedema) +/- skin oozing			
Getting washed and dressed			
Sleep- too much/ too little			
Problems moving around/sitting up/walking			
Other…… ……			
3. Do any of these words describe how you feel?	**Y/N**	**4. What is important to you?**	**Y/N**
Sad/upset		My faith and beliefs	
Calm/at peace/content		Having family/friends close	
Worried/scared		My culture and values	
Angry/frustrated		How I look	
Listened/not listened to		Music/literature	
Curious		Having someone to talk to	
Powerless		Feeling safe and relaxed	
Inspired		Being in my preferred place of care/death	
Challenged		**Would you like to see a chaplain/faith leader?**	
Isolated/lost		Other…… ……	

Please record your summary, assessment and plan of the patient's identified problems on the next page. **Ensure that there is a care plan for each identified problem or concern, including review date and time.**

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

Initial Nursing Assessment Summary

Section 1: Please give details if patient has answered yes to any symptoms or identified other physical issues

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Section 2: Please give details if patient/relative has identified any support needs

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Section 3: Please give details of interventions/support given if patient is experiencing negative emotions

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Section 4: Please give details of how those things important to the patient will be supported

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Assessment completed by:
Name *(print)* …… Designation …….. Signature ……

Completed and discussed with: *(please circle)* patient / relative / carer: Name(s) ……
……

Date completed: …….. Time: ……

Patient 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 support **artificial hydration / nutrition** if 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. Pressure relieving interventions and care of damaged skin should be implemented according to local guidelines. 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. If they wish, involve relative / carer in care giving. 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 symptoms** 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. ……
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Care plan completed by:
Name *(print)* …… Designation ……..…. Signature ……..

Care plan agreed and discussed with patient: Yes ☐ No ☐ If not, reason……
Care plan agreed and discussed with relative / carer: Name(s) ……..……..
……

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

Patient 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?

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Completed by:
Name *(print)* …… Designation ……..…. Signature ……..
Discussed with patient: Yes No if not, give reason……
Discussed with carer: Name(s)
……
……Date: ……..…….. Time: ……..