Example of Section 2 Ongoing assessment sheet for a non inpatient setting, where registered (trained) nursing care is not available 24 hrs per day e.g. patient's own home or residential care / community setting

Section 2 Ongoing assessment of the plan of care – LCP DAY……..

Undertake an MDT assessment & review of the current management plan if:

Improved conscious level, functional ability, oral intake, mobility, ability to perform self-care

and/ or

Concern expressed regarding management plan from either the patient, relative or team member

and/ or

It is 3 days since the last **full** MDT assessment

Consider the support of the specialist palliative care team and/or second opinion as required. Document all reassessment dates and times on page 3

Codes to be recorded at each timed assessment (a moment in time) A= Achieved V = Variance (exception reporting)

Record an A or a V not a signature

Date/Time per visit						
Goal a: The patient does not have pain Verbalised by patient if conscious, pain free on movement. Observe for non-verbal cues. Consider need for positional change. Use a pain assessment tool if appropriate. Consider prn analgesia for incident pain						
Goal b: The patient is not agitated Patient does not display signs of restlessness or distress, exclude reversible causes e.g. retention of urine, opioid toxicity						
Goal c: The patient does not have respiratory tract secretions Consider positional change. Discuss symptoms & plan of care with patient, relative or carer Medication to be given as soon as symptom occurs						
Goal d: The patient does not have nausea Verbalised by patient if conscious						
Goal e: The patient is not vomiting						
Goal f: The patient is not breathless Verbalised by patient if conscious, consider positional change. Use of a fan may be helpful						
Goal g: The patient does not have urinary problems Use of pads, urinary catheter as required						
Goal h: The patient does not have bowel problems Monitor – constipation / diarrhoea. Monitor skin integrity Bowels last opened:………………………						
Goal i: The patient does not have other symptoms Record symptom here……………………………………………………… *If no other symptoms present please record N/A*						
Goal j: The patient's comfort & safety regarding the administration of medication is maintained If CSCI in place – monitoring sheet in progress S/C butterfly in place if needed for prn medication location:………………………… The patient is only receiving medication that is beneficial at this time. *If no medication required please record N/A*						

EXAMPLE

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Example of Section 2 Ongoing assessment sheet for a non inpatient setting, where registered (trained) nursing care is not available 24 hrs per day e.g. patient's own home or residential care / community setting

Section 2 Ongoing assessment of the plan of care – LCP continued DAY….

Codes to be recorded at each timed assessment (a moment in time) A= Achieved V = Variance (exception reporting)

Date/Time per visit						
Goal k: The patient receives fluids to support their individual needs The patient is supported to take oral fluids / thickened fluids for as long as tolerated. Monitor for signs of aspiration and/or distress. If symptomatically dehydrated & not deemed futile, consider clinically assisted (artificial) hydration if in the patient's best interest. If in place monitor & review rate/volume. Explain the plan of care with the patient and relative or carer						
Goal l: The patient's mouth is moist and clean See mouth care policy. Relative or carer involved in care giving as appropriate. Mouth care tray at the bedside.						
Goal m: The patient's skin integrity is maintained Assessment, cleansing, positioning, use of special aids (mattress / bed). The frequency of repositioning should be determined by skin inspection and the patient's individual needs. *Waterlow / Brade score:……………….*						
Goal n: The patient's personal hygiene needs are met Skin care, wash, eye care, change of clothing according to individual needs. Relative or carer involved in care giving as appropriate						
Goal o: The patient receives their care in a physical environment adjusted to support their individual needs Well fitting curtains, screens, clean environment, sufficient space at bedside, consider fragrance, silence/ music, light/dark, pictures/photographs, nurse call bell accessible						
Goal p: The patient's psychological well-being is maintained Staff just being at the bedside can be a sign of support and caring. Respectful verbal and non-verbal communication, use of listening skills, information and explanation of care given. Use of touch if appropriate. Spiritual/religious/cultural needs – consider support of the chaplaincy team						
Goal q: The well-being of the relative or carer attending the patient is maintained Just being at the bedside can be a sign of support and caring. Consider spiritual/religious/cultural needs, expressions may be unfamiliar to the healthcare professional but normal for the relative or carer – support of chaplaincy team may be helpful. Listen & respond to worries/fears. Age appropriate advice & information to support children/adolescents available to parents or carers. Allow the opportunity to reminisce. Offer/provide a drink						
Signature of the person making the assessment						
Signature of the registered nurse per visit						

SAMPLE

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