Department of **Health Western Australia**
WA Cancer and Palliative Care Network

CARE PLAN FOR THE DYING PERSON – INPATIENT

Hospital: .....

Doctor: .....

Family Name	UMRN	
First Name	DOB	Gender
Address		Postcode

XY318300

Section 4: Continuing goals of care – minimum every two (2) hours

Care Plan day: **Date:**

Symptom management												
Code a Y or N at each time assessment	0200	0400	0600	0800	1000	1200	1400	1600	1800	2000	2200	2400
Is the patient:	**Y = Yes N = No**											
Free of dyspnoea												
Free of nausea and vomiting												
Free of pain												
Not troubled by respiratory tract secretions												
Free of restlessness/agitation												
Free of other symptoms _____												
Free of urinary problems												
Free of bowel problems												
Personal comfort care												
Code a Y or N at each time assessment	0200	0400	0600	0800	1000	1200	1400	1600	1800	2000	2200	2400
Have actions been taken to ensure the patient/patient's:	**Y = Yes N = No**											
Receives fluids to support needs												
Mouth is clean and moist												
Personal hygiene needs are met												
Skin care needs are met												
Eyes are clean and moist												
Physical environment is adjusted to support needs												
Emotional needs are met												
Is comfortably positioned												
Patient/family care												
Code a Y or N at each time assessment	0200	0400	0600	0800	1000	1200	1400	1600	1800	2000	2200	2400
Have actions been undertaken to ensure that:	**Y = Yes N = No**											
Procedures/care plan are explained												
Information regarding change is provided												
Family/carer is supported												
If 'NO' is recorded for any of the above, a further action is required and must be recorded on the Action report, Section 7.												
Nurse's name *(print)* **and signature**												

MR723A – CONTINUING GOALS OF CARE

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